Meaningful Use Workgroup
Draft Transcript
October 5, 2010

Presentation

Judy Sparrow – Office of the National Coordinator – Executive Director
Good morning, everybody, and welcome to the Meaningful Use Workgroup. This is the Federal Advisory Committee Workgroup, so there will be opportunity at the close of the call for the public to make comment. Just a reminder for workgroup members to please identify yourselves when speaking. Let me do a quick roll call, Paul Tang?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
George Hripcsak?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Bates?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Christine Bechtel?

Christine Bechtel – National Partnership for Women & Families – VP
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Neil Calman?

Neil Calman – Institute for Family Health – President & Cofounder
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Art Davidson?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
David Lansky? Deven McGraw? Charlene Underwood?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Here.

Judy Sparrow – Office of the National Coordinator – Executive Director
Latanya Sweeney? Michael Barr? Jim Figge is joining, but late. David Cabro is on for CMS, is that correct?

David Cabro – CMS
Correct.

Judy Sparrow – Office of the National Coordinator – Executive Director
Josh Seidman, are you on?

Josh Seidman – ONC
I am.

Judy Sparrow – Office of the National Coordinator – Executive Director
Anyone else? Did I leave anyone off the list? With that, I'll turn it over to Dr. Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Good, thank you very much, Judy. Thank you everyone for joining. Is this a public call as well?

Judy Sparrow – Office of the National Coordinator – Executive Director
It is a public call.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Thank you everyone for joining the follow-up meeting. I think we had a wonderfully productive meeting when we met face-to-face just a couple of weeks ago in Washington. We left the public and population health category to do today. In addition, we can come back and look at some of the things that we had left on the parking lot. One of the things I think Christine and Deven were going to provide a bit more input on the patient engagement aspects, the copy and access kind of a question.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, we're prepared for that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Why don't we get started with the public and population health? As you'll recall, all of them are menu items for stage one; though the provider has to submit one of the three as part of their chosen menu items. Right now, this is immunization data—immunization registry or immunization systems—to reportable lab data for hospitals, or to submit surveillance data.

In our stage three, one of the areas we heard certainly from both in our previous deliberations and from the public health testimony was the value of having bidirectional exchange with the public health agencies. Initially, it would be nice to report up, so that they have data. But certainly as we're seeing the new global trends in health and healthcare really mean that the providers should have information at the time they're seeing folks, particularly in flu season for example. As a placeholder, I put down stage three. This would be bidirectional exchange with the public health agencies in all three categories.

Let me open it up for comments in terms of stage three proposals. Then as you recall, work back towards stage two as an in between where we are with stage one and going to stage three. Also remind yourselves that in theory all of the menu items become required items in stage two. This may or may not be affected by how ready the public health agencies are by 2013. Comments?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Paul, is it a mandate that they become required? There's just no way around it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There's no mandate. What I would characterize it as a strong signal. They use various words in the final rule indicating that their plan was to change all of the menu set where you have some choice into all core or required. I don't know whether they have specific words around public health. As we all know that each state public health agency is in different state of readiness. So it's unclear to me that they would be

able to enforce that, i.e., make it core for everyone in the country because I'm not sure every public health agency would be available to receive this data electronically.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I gathered some input on this. Regarding the question David just asked, some of the providers that are in stage two feel that by stage three there's no way they're going to have an infrastructure in place to be able to do some of this. So I think that's definitely going to be the case.

However, on the other side of it, there are some states that are pretty aggressive and they're already defining this stuff. There's concern that as the states move forward on this, it's going to be potentially inconsistent with the national standards. So there's some concern on that side. Our understanding what the RECs are doing and the states are doing are pretty important.

Then the other piece of it is in the discussion among the vendor community exactly what bidirectional means is kind of important because there's a lot of it under all of the categories, but if you think for immunization, okay. You kind of said okay, it needs a—if you send immunization and you want an acknowledgement that it was received, what does bidirectional mean? There's so many of these cases for that.

It's a pretty vague statement and a pretty broad statement as it's currently specified. So if there's a way to specify a glide path or something like that, I think that's going to be important. Because as we work backwards, again, given some states are going to get there anyway, but what might be the incremental steps that people can take to get there?

Art Davidson – Public Health Informatics at Denver Public Health – Director
In response to your question based on the standards there is a way to receive back the immunization history on a patient. Again in the standards, there is a way to receive what is the recommended vaccine for a patient. So those could be two items more specifically.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
For recommended vaccine, it seems like you'd have to know quite a bit of information or is it just based on demographics for example?

Art Davidson – Public Health Informatics at Denver Public Health – Director
You have to look at the prior immunization record as well.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm saying some of the vaccination recommendations depend on a clinical history. Let's say chronic respiratory diseases for example or diabetes or splenectomy. There's all kinds of clinical variables it seems like you'd need for true recommendations that are personalized to an individual.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right. I think most of the recommendations that we have been working on over the last decade or two were directed at kids. But I agree with you, you would need to know something about their medical history as well. It's mostly timing and age and prior history of shots for kids.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so that's one answer to Charlene's question. A more general answer is I think it's still a lot to be determined. One of the things that have come up recently of course is the changing kinds of flu vaccines, like H1N1. Not only would it be nice to understand is it affecting my area, is it affecting the ... probability of the person in front of me having H1N1? A lot depends on whether the epidemic has spread into my state or my county even. Then as you know that the actual recommendation for the vaccine can be updated almost daily. Sometimes you have a problem with supply, etc. Those are the kinds of things that would be—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Sorry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, go ahead.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, as you were drilling down, there's like even kinds of alerts then. There are the general alerts and patient specific alerts too, categories of that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think what we're trying to put in a placeholder for 2015 is still five years away. It depends a lot about the infrastructure for our public health system, which I think a lot of us have less control over, although there's some money going into that, it's probably not enough. Our sophistication in terms of what data can we pass, just as we had this interchange with Art, you can begin with some of things that are almost demographic or age specific like childhood vaccinations, but then it starts to get more complicated.

You need to know more information, either because it gets queried or we have special rules that are implemented at the federal level that everybody can run by. Then it requests a specific set of data that the EHRs respond to. You can imagine how this can be one, very helpful, but two, become very sophisticated. I think we're going evolve those requirements and capabilities over time. I think it's just a heads up and it's bidirectional at this point.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Let's take the immunization as the example. Number one is you have a menu item, which says all you have to do is test it and only use it if the health department can get it. Then we can make that thing mandatory that you tested, but still only use it if your health department can handle it. Then there would be theoretically I guess making it mandatory that you have to do it.

Then on bidirectional, there's getting data from the health department in terms of what happens to be in whatever registry they have for immunizations. Then the step after that would be to get decision support from the health department in recommending a specific shot. But you could do bidirectional by just getting the opportunity to look into their registry and that may be the one that gets at 2015 with the decision support further in the future.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That seems fair. Art, do you think we'll have that capability?

Art Davidson – Public Health Informatics at Denver Public Health – Director
I think Charlene brought it up earlier, there are some states that are probably going to be able to do bidirectional response for immunization history probably by 2013 and there are others that will probably not be ready for that by even—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Twenty fifteen.

Art Davidson – Public Health Informatics at Denver Public Health – Director
—twenty fifteen. There's going to be a spectrum here.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. The concern from the community is like the variety.

Neil Calman – Institute for Family Health – President & Cofounder
I just want to ask, maybe this is a little bit off track, but are we calling out that this is the best solution for coordinating immunizations across the country? In a conference set that we were running a couple of days ago, the subject got brought up, why are we even doing it this way when there are state

recommendations in addition to sort of national recommendations. There's local, New York City has its own immunization guidelines.

What are we expecting the EHR decision support? Wouldn't it be better to build a different type of model where the health department was the repository for all of the information? The EHRs had an ability to look at that and use the decision supports that were built on the health department side.

I'm not suggesting that as a different solution. All I'm saying is like calling this out the way we are, are we like trying to create a solution for this very complex problem that I'm not sure anybody's really gotten to work perfectly yet? Would it be wise to kind of step back from that and let this evolve in a way that might create a different, more workable solution for the country?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's a little bit of what we've sort of arrived to in the discussion. George, I think somewhat suggested this earlier, that is some of the decision support, let's say is beyond the 2015. What we're trying to do and ... and not succeed in doing that is to get all the states to be able to not only receive, but share back immunization history. You can see that that is sort of a fundamental, but there's some concern that that might not even be reachable by 2015.

But what we could do is set a goal and get feedback as we all acknowledged last time, we're sending this out for an RFI, get feedback, and at least start introducing the idea that at a minimum what we would like to do is be able to query for what are the immunizations of this individual, particularly, this child has had throughout the country? That certainly would be useful and it's just a stepping stone on the way towards decision support, whether it's done centrally or in a federated model.

Neil Calman – Institute for Family Health – President & Cofounder
So I guess this just depends upon what you're requiring the EHR vendors to do. It's different if you're allowing them to be able to just catch, look at the data, send the data to the immunization registry, and then be able to view it so that it informs the provider what to do next versus maintaining immunization data within the EHRs. I guess that's really the question.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
When you say maintain, you mean if you receive it, then to maintain the consolidated record?

Neil Calman – Institute for Family Health – President & Cofounder
Yes, within the electronic health record itself, because that only gets updated when there's some connectivity, right? I mean the question is whether or not the same data exists at the health department as is going to exist within the EHRs and what the best way is to make sure that that happens?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Well Neil, you're going to want a copy of the EHR because you've got to document what care you provided. But I agree someone has to be responsible for remembering that this kid hasn't been immunized. Someone has to send out preventive care reminders. It makes more sense for the city or the state to do it than the healthcare provider, because the city or state knows what all the providers that child saw. So they would send more logical alerts probably in the long run. But the care data should be in both places.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
May I just interrupt for a second? Whoever is running the slides on the WebEx, would you mind putting up the metrics that we had from last time? Okay, go ahead.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I think what I just heard, Neil, from George, I basically agree with it, taking an action you would want to know what the prior history was for that child. But I also agree with you Neil that the whole concept of creating the logic may not need to reside inside of the EHR. It may be something that you depend on

from some centralized or federated knowledge management system that says what shots should be given.

Neil Calman – Institute for Family Health – President & Cofounder
And that's likely to have some local content.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes, of course.

Neil Calman – Institute for Family Health – President & Cofounder
That's why I think it's difficult if you think about that logic existing on the EHR side. It's difficult to imagine how a vendor is going to maintain that in relationship to what local recommendations and things like that there are.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I agree with you. I think that having that as one central source in a city or state or wherever, that someone would just hook their EHR up to that and say, "I'm using this knowledge management system."

David Lansky – Pacific Business Group on Health – President & CEO
I like Neil's issue there that's being raised. I have basically a naïve question about the evolution of the public health data infrastructure around the immunization registries. Listening to this, I'm, in a friendly way, skeptical that we can be confident in some timeframe that there will be a national immunization data infrastructure that will do the things we're talking about in a reliable way for a population that is transient and all the factors affecting people's stability in reporting and so on.

The other paradigm obviously is more of a PHR based paradigm where the registry is maintained where the immunization data is maintained by the family in some way, which has similar vulnerabilities or different vulnerabilities, but another set of them. I was just wondering is there some other, back to Neil's main point, some other approach we could think about in which the EHR is generating and interfacing with a variety of data aggregation platforms, which include immunization data? But we don't have to make too strong of an assumption today as to what that public health infrastructure will look like.

Also if it ends up being more viable to support it through a personal health infrastructure with cell phones or whatever, there were people managing their health records five years from now that we have that capability built into this meaningful use criteria.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm not sure how many different possibilities you're trying to incorporate in here.

David Lansky – Pacific Business Group on Health – President & CEO
Mostly I wanted to question the assumption that we have a clear picture of what the public health immunization data infrastructure will look like in terms of both aggregation, reporting history, the clinical decision support or the intelligent engine behind it. Do we have a clear picture that in 2013 or 2017, that's going to be largely uniformed across the country and it's a reliable infrastructure to which the EHRs communicate?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I have to say that we certainly do not have a clear picture. I think what we're trying to do is establish some kind of base functionality that we can't even say with great confidence would be uniformed throughout all the 50 states. But the base information would be you would like to be able to query and find out what the public health agency that you're connected to, what information it has on this child for example? Recognizing that it may not know all the ones from the other states. It all depends on the architecture and how the federal system gets brought up. One of the things we're trying to do is at least query and being able to receive a response about what does the agency I'm querying know about this individual?

David Lansky – Pacific Business Group on Health – President & CEO
I'll just say it may not be an agency; it may be you want to talk to the Kaiser infrastructure, because you've got a patient in Palo Alto—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

David Lansky – Pacific Business Group on Health – President & CEO
—or maybe you want to talk to the Microsoft HealthVault infrastructure because the patient is maintaining their health record there. I don't know, rather than presuming it's going to be a public health agency backbone, maybe we should make a more generalized assumption about this bidirectionality.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The attempt is local accuracy of immunization history. What it seems like, I think we need to specify intent, because of what you're talking about is inquiry. How to get it is less critical. But definitely, you've got to get the intent down in terms of what you're trying to do. I think that would even really be helpful in the context of the policy right now, because the feedback we're getting, what are they trying to do here?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'm not sure. Art has got the good concept, but that's not necessarily general knowledge either.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Let me just respond to David if I might. Indeed, one of the things you'll want to do is make sure that the right shot is given to the right child at the right time. But the other thing is the population perspective is to say, so how many H1N1 vaccines were given out in this period and to what risk groups? If everything is stored in a PHR and we don't have a way to query that PHR for that population perspective, then we're not serving all the public health needs here. That's part of the reason for the development of immunization registries over the last decade or so is to allow that sort of population perspective to emerge.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let me add on to that. Art is exactly right. The original intent, in Charlene's words, was for the public health agencies to be able to execute its functions on behalf of the public. So that is really some governmental agency that is trying to assess the health status of the population and public.

When we went to the bidirectional and with our experience in these unique flu's in the various years we've had, we also saw the need for the provider to be informed about what's happening in the public. It turned into having two different kinds of needs. The latter, the provider needs could be satisfied one-by-one as David Lansky's example pointed out, you could say, "Oh, this patient's been seen by this other group and let's go through that." But it might more efficiently be satisfied when a public agency, and that's a broad term, has gathered information about this individual throughout the provider enterprise.

So maybe we need to find a way, this area, and may I suggest to whoever is working the spreadsheet, could you contract some of these columns so that we can see the columns over to the right, because that's where we left off and they're blue in color? So maybe one way is to follow something like George was suggesting. So for example in stage two we're taking, right now everything is optional in stage one, and in stage two you may need to perform the test and if there's nobody in your district that can receive it, you have performed it, but nobody was home and so that test has failed but for this reason. But move it in that direction where more people are actually executing the tests.

Then in stage three, at least signal and perhaps we use the imperium styles saying, "Here's the situation, what's your advice?" Actually solicit input from both the public, but also the public health departments in the various states. But looking for this basic functionality being able to receive reports of immunization

from the various provider organizations in your district, as well as respond to a query about the immunizations on this individual. Does that seem like a decent starting place to gather information enough?

David Lansky – Pacific Business Group on Health – President & CEO
Okay.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think so.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes, I think I agree, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So that takes care of the three menu items. We had heard from the hearing, one example we had was the public health submission button. There's a number of things that a provider is required by federal or state law to report on, but often times you don't report on because it's so hard to, one, know what's reportable, and two, how do you find the right forms, and three, how do you get it to that entity.

The idea was if you could even have an alert that this is a reportable condition or lab test result, can I hit this button and select from this list and then have it sent? What do we think about that? Well, it's certainly going to depend on all the conversation we have, which is certainly not all states are even going to have this ready by the 2015.

Art Davidson – Public Health Informatics at Denver Public Health – Director
One of the things we should consider is in stage one, hospitals or laboratories in hospitals were required or offered the menu option to do electronic laboratory reporting. That left out eligible providers from reporting.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Art Davidson – Public Health Informatics at Denver Public Health – Director
There's a gap there that I think the public health community would like to see remedied. It could be through this button. Now a lot of state health departments are capable of receiving that electronic laboratory reporting now. I don't know how much of a stretch it is to say that they would be receiving from providers reports. There's no need for it to be bidirectional at this point. We're just trying to get the reporting to be accomplished.

Neil Calman – Institute for Family Health – President & Cofounder
I think this is an area where the button function could be separated from the means of transmission function. So we could call out that the button, which is really an EHR functionality, could go in a couple of directions. If the health department is able to do that electronically by a certain date, then the expectation would be that the provider would do it electronically.

But if not, the button functionality could generate a printed copy that could be faxed or could go out through a fax server to the health department. But in any case, this would vastly improve the reporting of reportable diseases. I think we should keep the button function and I think we should allow for variability in the mode of transmission to the health department based on the capability of the health department to receive it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's a good point. It's a little bit like CPOE. As long as you're having the feedback, and in this case having the feedback to know that this reportable, and then in the convenient fashion get it to where it needs to go or at least part way to where it needs to go that's the service. No, that's a good point. How do others feel?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Again, I think the challenge is as the providers and the vendors have lots to develop and unless there's someone to be able to send it to, there's got to be someone able to be receiving. The states are varying all over the place in their ability to be able to do this.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I think Neil just gave us a good example of how a state that's not enabled yet can still benefit from the button by having doctors have a quick way to do what they should be doing right now.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Let me just comment that we did something like this for every ... events and then packaged up some data from the electronic record and it worked really well, providers liked it a lot, and it wasn't too hard to do.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, this is a great fine. It's basically making it easy to get information to people who can deal with it. If it goes directly to the report agency, that's great, if not, it's certainly of help both to the provider and the provider organization to aggregate it, to accumulate it in somebody's inbox so that that person can take care of it.

How does that feel, Charlene? I mean it's a new functionality for the EHR, but I think it's a very useful function and it really nicely finesses whether there is an electronic receiver or not.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes. It seems to make sense. You've got to get the data organized so that you can send it. What I don't know is because of the variability, the scope to which it's going to, how much work it's going to be for the vendors to get that there and what stage. But clearly getting the data organized such that they can send it and get it in the right standard, I think gets it at least going in the right direction.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So I think we—

Neil Calman – Institute for Family Health – President & Cofounder
I'm sorry, Paul. I was just going to ask, are we also calling out the need to have the appropriate decision support in the system to support the reportable diseases or at least call? I think that's not really, the vendor function is to allow people to build decision support, but I think for meaningful use this is a great use case for decision support. A fairly simple one to implement, which is that people should have decision support in their system that flag the providers to report reportable diseases.

Art Davidson – Public Health Informatics at Denver Public Health – Director
During our testimony we heard from the council, State and Territorial Epidemiologist, about the standards that they are developing with CDC for this to happen on a standard basis across all the states and territories. I think there's an emerging standard here that we could ask the vendors to follow.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. I think this is a nice idea, are people in agreement with this for 2015?

M
Yes.

M
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Alright. Who's got control of the spreadsheet? Okay, so could you put in column I, so that would be row 66, column I, in red, put electronic transmission where accepted, and semicolon, vendor functionality to

accumulate this information and transmit manually when electronic submission is not accepted, something like that. We'll fix the text later.

Great, thanks, and another one, vendor support of CDS to detect, to identify reportable conditions. What, you ran out of room there, let's see?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Neil, as you think through this, where we get lots of pushback is okay. Here we're doing something and it's with some higher power and we're not getting our immediate need function met. The benefit to the provider in this case, again, the intent, how does this help locally then?

Neil Calman – Institute for Family Health – President & Cofounder
This isn't really a benefit to provider issues.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I know, I know, I know.

Neil Calman – Institute for Family Health – President & Cofounder
This is the public health part of meaningful use.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Is it going to support—

Neil Calman – Institute for Family Health – President & Cofounder
In my opinion, this is the most important piece of the public health part, because it really enables the country to begin to develop a sense of what the disease burden is of important diseases across the country. Not everything is going to be to the benefit of the providers, we're calling out stuff that's for the benefit of the patient and other stuff that's for the benefit of public health.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So whoever is writing here, I think you're asking for, so instead of vendor support, why don't you put CDS support—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
—and CDC support for identifying reportable conditions. I think we'll remember what that is then based on that. Okay, thank you.

While we're at it, let's go up and finish the row 62 through 64, and changing stage three. Let's do comments now, we can fix the words later. We changed this basically to support for querying, in row 62, support for querying immunization registry. Then in row 63 and 64, it's similar, but it's just not, let's see reportable lab. We didn't actually say this, reportable lab data and surveillance data, are we expecting a query of some kind of registry in those cases as well?

Neil Calman – Institute for Family Health – President & Cofounder
Well that's really back to, first of all, it's reportable lab and it would be diagnostic data as well, because some reportable diseases are not reported just through a lab test, that's one thing. We should apply this to the eligible providers, as well as hospitals. Some of the things that you wrote on that line 66 really fit in this box I-63. I think that got sort of merged down there with CDS support.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well, no, if you cleared a part, we were talking about row 66, because we're trying to say, in support of the blue button, you'd like to have CDS support that notifies the provider of this lab test result is reportable

for example, or even this diagnosis is reportable. I think you're correct that we could have said that back up in 63 as well, but we didn't yet.

Neil Calman – Institute for Family Health – President & Cofounder
Yes, we didn't yet, right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Now why did we put hospital, limited to hospital in the first place? I thought it was maybe a JCO requirement or a public health requirement that's served by the hospital.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Both providers and hospitals are required to report. So laboratories report a series of diseases as do providers in virtually every jurisdiction. I believe that that's a requirement. I don't know why we just selected hospitals, but that's something I think we might want—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Art, isn't it these hospitals actually have labs that produce data that do the lab tests and that's what we wanted to report to the health department where the doctor offices usually outsource that to either a nearby hospital or to an outside lab, and they have to report to the health department directly.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right.

Neil Calman – Institute for Family Health – President & Cofounder
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think that's how we got that.

Art Davidson – Public Health Informatics at Denver Public Health – Director
That is true, but the trouble is that the labs had incomplete demographic data for almost all the tests that they do. That's why public health departments have to go back to the providers to find out more about the patient and how to begin the investigation.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So that's reportable conditions, not so much reportable labs. When you say reportable labs, you mean diagnostics that I think what health departments consider diagnostic, which is actually you get the lab result and you send it off and they're sure of what was found—

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
—versus reporting a condition, which you do on a form where you fill out all the symptoms and everything and send that presumptively. That is a new thing I think, which the hospitals, any eligible professionals can both do. Now there may be some lab tests be done in doctors' offices, and that's a different story. I'm not sure whether we need to handle that in meaningful use or not.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
This process is so broken, you guys. I sit here trying to think about, we've tried to automate this space. If I looked at simply a couple states we've worked with, they get them from the labs, they get them from the hospitals, they get them from the doctors, and only a small percentage of the case, when it gets to public health, they have to try and reconcile the encounters.

The patient numbers aren't linked up, so they have to manually sort them. So you're really pushing forward on automating processes, which you want the best case process to happen so the immediate

information is available to the provider. But at the back end, to ask to automate something like this, it's not going to work at the end of the day unless this is thought through a little bit better. So there's a lot of intent here and it's all good, but just know that the infrastructure to support this is all over the place.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I don't know, I think the things we've written down are just automating the parts of the process that are already there. Doctors are supposed to fill in a form and send that to the health department. So instead we're saying that the EHR can have you fill out the form. Now what happens when you push a button as Neil said is a different question.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And some doctors will say, "Well, my lab sends it in," other doctors will say, "Well, I'm going to do it or not do it." There's no penalties ....

Neil Calman – Institute for Family Health – President & Cofounder
Better policies.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
There's a state law that says what the doctors have to do, which is different from the lab report.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We can put this down here, it's just a mess that's all.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But if we do nothing about it, then we get nowhere.

Art Davidson – Public Health Informatics at Denver Public Health – Director
No, I think we have to do something, but I also think that the process needs to be rationalized over time.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
If we take the parts that we know have to be done anyway. In other words, so there's one vision where there's a central management of all immunizations and all the decision support occurs centrally. That's a hard thing, Charlene, that I agree. I don't know that we can legislate that in meaningful use. You could argue that diabetes care should be managed centrally by, I'm not saying, I'm not proposing that ....

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I mean—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I'm just drawing an analogy there ....

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'm not fighting public health, just that people are in so many states of this.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The question for us is to come up with a rational next step that are reasonable to ask to happen. So I think sending something to an immunization registry is probably a reasonable step. Someday, getting information back from the registry you sent it to is probably a reasonable step. Coming up with an electronic version of health reporting forms may or may not be reasonable, but it's probably the next step after those other two.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, and again, I think this would be the great space to get feedback from the states in terms of where we can get some alignment possibly. Because as I think this through, the step you're going to want then is once that data comes back, the whole reconciliation process locally, which would be really powerful. But

you want clinical decision support, but you really want it reconciled to the local record and then another feedback.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So in a sense, these steps that we're talking about concretely right now, it's like it's analogous to stage one where we just wanted to collect the demographic and then start using them for outcomes by stage three. So here, we want to get this information flowing among the entities with some future stages beyond stage three to figure out the decision support.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So for reportable, maybe we need to separate reportable lab versus reportable conditions.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So reportable lab, what would we like to propose for comments for stage three? Being able to query? It's a little tough.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I'm still not sure that eligible providers need to do mandatory lab reporting. First of all, mandatory lab reporting is mandatory, so they've got to do it anyway at the hospitals. I guess, just the matter whether you're using a PHR—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
In the lab ....

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The lab does it, yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
The providers don't have to do mandatory lab reporting, they have to do mandatory reportable notifiable diseases.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Right, that's what we were calling conditions.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So let's separate, so first for row 63, if it's written reportable lab data and that's what's in the rule, so let's stick with that for right now. George is right in terms of why we limit it to hospitals, because hospitals have labs, EPs don't. So if we can add the condition in a different row. So for reportable lab data, I'm not sure we have a clear, even for stage three, a clear request.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I propose it should be mandatory.

Art Davidson – Public Health Informatics at Denver Public Health – Director
It should be mandatory.

Neil Calman – Institute for Family Health – President & Cofounder

I don't think this adds anything. If there's already a requirement, a state requirement, to do this, and the labs that are licensed have to report this stuff. Why are we in the middle of this issue?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's the electronic report.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes, it's mandatory electronic.

Neil Calman – Institute for Family Health – President & Cofounder
Right. But it's not a requirement, it's not a provider requirement, it's a lab requirement.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we've agreed not to make it a provider requirement for lab data. So right now we're just asking, what would be stage three criteria if any for hospital labs?

Neil Calman – Institute for Family Health – President & Cofounder
So I'm saying there is none, because that's going to be a requirement that's going to be imposed from other places. It doesn't need to be part of meaningful use. It's going to be imposed by states or local health departments, whoever requires that reporting is going to require the institutions to do it. At some point that's going to be required to be done electronically. But I don't think we need to call that out. I just don't think that this adds a lot, given all the other stuff that we're doing.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I think it's pushing the agenda that it has to be reported electronically earlier.

Neil Calman – Institute for Family Health – President & Cofounder
But that agenda, we don't really have any ability to push that agenda for commercial labs. So we're pushing it for hospital labs when it doesn't necessarily just for commercial labs.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right. That's why, the commercial labs, especially the commercial labs that service independent providers who are not using a hospital lab. Those reports are the ones that eligible providers need to report as a notifiable condition.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Right, with their button.

Art Davidson – Public Health Informatics at Denver Public Health – Director
That's right. That's why we need to get into the eligible providers. Let's finish the discussion about the hospitals, and I agree with the way Paul is trying to segment these.

Neil Calman – Institute for Family Health – President & Cofounder
Okay.

Art Davidson – Public Health Informatics at Denver Public Health – Director
And then we'll get back to the eligible providers.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So Neil, I agree with your comment, but we've got a requirement there, so the question is do we drop it or do we make it mandatory by 2015?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Which requirement?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

The hospital—

Art Davidson – Public Health Informatics at Denver Public Health – Director
That you would be able to test, yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The hospital reportable labs to the public health department electronically.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Again, the issue there, and I think there's enough exclusions there, because they sometimes come from reference labs too, so that's just—and sometimes it comes from the lab system, which I know that you don't like, but again, then that implies the lab system. This is the stuff I'm hearing back, then the lab system has to be certified and we don't want that to happen. So there's a lot of variability in this space.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think George has called the question—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It needs to be on the intent.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think George has called the question. In other words, it is a menu item that CMS has proposed will become mandatory in stage two. Are we accepting that and create that mandatory at stage two and three or are we saying we actually are challenging whether that should be a part of meaningful use at all?

Neil Calman – Institute for Family Health – President & Cofounder
I don't think it adds anything new that's not going to get done otherwise. So if parsimony is part of our required consideration, I don't think that this adds a lot.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Meaning drop it completely?

Neil Calman – Institute for Family Health – President & Cofounder
That would be my statement, but I'm perfectly willing to keep it if others think that it adds something.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think the one choice, Paul, is to actually in our thing, we can have a running commentary just like the event did. We can say that we're supportive of this becoming mandatory in 2013, but because it's mandatory anyway for parsimony, CMS could consider dropping it all together.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I like that. It's not mandatory electronically and where applicable meaningful use is to encourage the adoption of the electronic both the standards and the use. So I think it's within the scope of meaningful use to do this. We may be saying it may be out of bounds from a timing point of view and there are other controlling factors that would cause it to happen at an appropriate pace.

Neil Calman – Institute for Family Health – President & Cofounder
But also there are two entities here—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
—of which we don't control. One is the health department and the other is commercial labs. So we're sort of picking up one of the entities, which is the hospital piece and not really. This isn't like a total solution, it's just a little piece of one that's going to have to be solved in some other space.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
By the way, I just wanted to make sure somebody is taking minutes, is that correct, Josh or Judy?

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes. It's also being transcribed, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Great, thank you. Do we want to get a sense of the workgroup in terms of either write this kind of rationale for not pushing on it further or leaving it the same only trying to get mandatory? Leaving the item in, the criteria in, but just moving from menu to mandatory testing versus sort of dropping it for the reasons that Neil has raised. How do people feel about one of those two options?

Art Davidson – Public Health Informatics at Denver Public Health – Director
I feel it needs to move to mandatory. Electronic laboratory reporting definitely improves the comprehensiveness and the timeliness of surveillance data. I think to ignore that would be to ignore what's been the thrust of about 20 or 30 years of work.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I understand Neil's comment. But it's okay, I think we follow CMS' lead to make it mandatory, but insert Neil's comment in our commentary that we hand to CMS. That is if they feel like parsimony, then they can do it, but otherwise we're following their lead. Neil, it's not bad to push forward on multiple times ....

Neil Calman – Institute for Family Health – President & Cofounder
I'm not—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It's okay, I agree. If we have too many of these things, this would be one that we can drop off for the reasons you see.

Neil Calman – Institute for Family Health – President & Cofounder
I'm totally fine with that.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Neil, then I would recommend we keep it and don't make it mandatory, because there's just so many places that can't do it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The goal is to test it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So mandatory is testing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It's not actually sending.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Other committee, workgroup members? Are you on mute?

Deven McGraw – Center for Democracy & Technology – Director

Yes, we were. Sorry, Paul, I joined late, so I must admit that I'm not completely in tune with what we're deciding here. But since it's public health and Art is not protesting, I'm fine.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Anybody else? Christine, David, David?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Yes, I'm in favor of including it.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I agree.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is it Alison who's running the spreadsheet?

Moderator
Caitlyn.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, thanks, Caitlyn. Would you mind putting in stage two then mandatory testing and then stage three mandatory testing. Actually the same is for stage two of row 62 for immunizations. You can actually just delete what was there before and just put mandatory testing. Okay, thanks in stage, yes. Do we want to separate now, recall this is now going to be, and actually what you can do I think for row 62 is copy the comments into stage three. Thank you.

How do people feel about the reportable conditions that would be a new criteria? We always pause when we add more to this list, but how do people feel about that?

Art Davidson – Public Health Informatics at Denver Public Health – Director
So let me just understand, Paul, did we agree that we liked the idea of the button or not? Is this independent on that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, this is independent of that. In fact, I think that brings up a good point. I think the button, it's recognizing that what you want to do is make it trivially easy. That's sort of the first rule of EHR, is trivially easy to do the right thing, whether it's to do the right order or do the right reporting function. I think the button has been a good way to do that and there's a nice hedge about if you can't send it electronically, at least make it easy to get the thing faxed for example.

You could consider that as fulfilling this other requirement of assisting people when they're trying to act on reportable conditions. Is that fair, Art?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The incent then would be to, you're going to try to ... something outbound, but it could be in a lot of different forms then.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes, based on what Neil had suggested.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Okay. So let's move onto surveillance data. Do we want to take the same approach there, which is basically make this menu item mandatory, mandatory testing, and submit where successful.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It says the requirement says test and submit if test is successful so it goes a little bit further.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I was saying that when you start talking, but—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I'm sorry.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
—in each of these cases that's what the language is testing and submit where accepted.

Neil Calman – Institute for Family Health – President & Cofounder
Does the CDC accept directly Syndromic Surveillance data?

Art Davidson – Public Health Informatics at Denver Public Health – Director
From the hospitals and large organizations up to now, to the BioSense program, they do. The CDC, however, in the more recent past has been evaluating through the International Society for Disease Surveillance other methods that use local jurisdictions to aggregate the data and then share it on a federated basis. I think CDC in the past has done what you asked, Neil, and it's uncertain whether that will be their model going forward.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But Neil, BioSense is a subset, is a sample of hospitals around the country. It's not a pervasive program.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
But I was just looking to see if there was some receptacle or recipient I guess would be a better word for this information irrespective of what a local health department could do.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Not really.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Instead of the local health department to—

Neil Calman – Institute for Family Health – President & Cofounder
No. But in order for us to call this out as something that everybody should do, if the local health departments could not accept it electronically, was the CDC able to accept it electronically directly. The answer is no, I guess.

Art Davidson – Public Health Informatics at Denver Public Health – Director
At this point unless they follow the BioSense model, no, at least to my knowledge.

Neil Calman – Institute for Family Health – President & Cofounder
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So what are we doing with Syndromic Surveillance, moving it to mandatory testing and submit where accepted?

Art Davidson – Public Health Informatics at Denver Public Health – Director
I think that would be the proper next step.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is that the stage three as well?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that's true, it's so heterogeneous at this point.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's an unpredicted source.

Neil Calman – Institute for Family Health – President & Cofounder
What would it mean for an individual doctor to mandatorily test their Syndromic Surveillance? How would I as a private practicing physician actually go about testing this?

Art Davidson – Public Health Informatics at Denver Public Health – Director
So currently the CDC has a contract with the ISDS, this is outside of the ... surveillance to help develop some preliminary guidelines around how you would do that. An HL-7 specification is floating around for review right now to help you or your vendor figure out how to do this.

Neil Calman – Institute for Family Health – President & Cofounder
So the vendor piece is a certification issue.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right.

Neil Calman – Institute for Family Health – President & Cofounder
But I'm asking, I'm in my office now and I'm reading this thing and I'm trying to be a meaningful user, and it says that I need to test Syndromic Surveillance. I'm sitting there trying to figure out, what the heck does that mean? What am I supposed to do?

Art Davidson – Public Health Informatics at Denver Public Health – Director
So it was—

Neil Calman – Institute for Family Health – President & Cofounder
How do I make my machine do this test?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right. If you're dealing with a certified EHR that is capable of submitting this, you would then work with your local health department the same way you would for the blue button or whatever color it is to send information to that local or state agency to receive it. They would have to be ready to receive just as we talked about earlier, either they're ready to receive a fax and so they're not able to receive a reportable disease or they're able to receive electronic format and able to process the data. It's all based on having an EHR that's capable of sending this HL-7 message that's being vetted right now.

Neil Calman – Institute for Family Health – President & Cofounder
Right. So playing the parsimony role again, if we're certifying that the system can do this, then we really don't need the providers to test them, that they're already tested in the process of certification. What we really need to say is if the local health department can accept this data that the providers are required to

submit it, to flip that button on if their local health department can do it. But I don't see any reason to have a local provider try to figure out what it means to test their system.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I tend to agree with Art. The local health department in certain counties could be a person sitting at a desk. It just depends on the context, so then it would jump up to the state level. So will all 50 states produce testing facilities? If not, then the CDC, and do they want to really service 100,000 or 200,000 doctors trying to test their EHRs, whether they can send up a couple of messages?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes, I don't think—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
It doesn't sound feasible. ... a little better.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
The surveillance stuff is kind of a byproduct of you're just hopefully ... and then you can pull the surveillance stuff as a byproduct of the workflow and then just submit it. So it's exactly what George said, it's just a transaction that gets posted.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, so should we take the same approach that we did with the button, which is these things if they're not accepted should at least make it efficient for the provider organization to accumulate this thing to deal with manually?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
We don't, that's not—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
....

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
This is a large volume.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
They can choose, yes.

Neil Calman – Institute for Family Health – President & Cofounder
This isn't a manual function.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes. This isn't large, but it's every ED diagnosis, you don't want someone to have paper that has every ED diagnosis on it.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Neil Calman – Institute for Family Health – President & Cofounder
Yes. The process includes vital sign information and all kinds of other stuff. I don't think there is a manual counterpart to Syndromic Surveillance.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Should we have included it with the reportable lab data?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
How would you do that, I mean it's that same concept?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's that it would go to, at least it would be, one, it would get reported to somebody who could do something about it. If it takes a human intermediary and goes through paper, even the fax, then that's still accomplishing, it's addressing the need, and it's also streamlining the process for the provider organization, the hospital in this case.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, like for what you do, you identified the data, you pull off condition, maybe dates, sometimes location is just a few data elements to do the initial surveillance, so that's really tricky. I'm not sure how much value that brings, because you don't even know who it is. You're just trying to pull some data, there are a lot of flue or conditions of different respiratory conditions. I'm not really happy with that.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes, I don't think this can be used if you're sending some sort of paper record. Because a lot of the Syndromic evaluation is based on processing and parsing the chief complaint.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, okay. Caitlyn, would you mind in row 64 adding to column A, the label of this row, add Syndromic Surveillance, so Syndromic in front of surveillance please. Thank you. Then for stage two and three, it's the mandatory testing, semicolon, submitted if accepted, and that actually is true for all those mandatory testing. Okay, are we finished with the population ... then?

Okay, the final category is the privacy and security protections. Where we are with this is we've had a couple chances to try to suggest something more, either more in terms of the privacy and security protection or essentially the penalty for not complying with the original HIPAA requirements, both efforts failed. Do we know why it was taken out, is it possible that it's sort of beyond our scope? I think that was sort of the language in the final rule. ....

Deven McGraw – Center for Democracy & Technology – Director
Paul, there was a lot of language in the rule that talked about not using the meaningful use criteria as a way to enforce HIPAA. I actually questioned both David and Tony Trenkle about this, because I just didn't see, if we weren't going to look at HIPAA, it was hard to see what kind of advances we could make in this category, and what was the purpose of maintaining it as a category if it didn't have anything in it. I don't know if you remember this.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Deven McGraw – Center for Democracy & Technology – Director
The response from David was a bit more encouraging than I had seen in the rule. My sense is that part of what, although this was never expressly stated, but I think part of what was causing CMS some hesitancy is that it wasn't part of the proposed rule. So there wasn't really a full opportunity to comment on it and it didn't actually get added as a recommendation until the privacy and security workgroup raised it. That was kind of much later in the game than when we had come up with our original metrics.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
What would you add from the privacy and security workgroup?

Deven McGraw – Center for Democracy & Technology – Director
I would add two things, one, being the very carefully worded recommendation that's in essence if you're guilty of a really significant, i.e., willful neglecter, criminal violation of HIPAA where you've sort of done your due process and you're at the end point and you're paying money or you're in jail, that you shouldn't be eligible for meaningful use in those circumstances. Then the second one would be actually requiring people to address how they're going to use the security functionalities that are in certified EHRs.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So are you saying that neither of those were in the NPRM?

Deven McGraw – Center for Democracy & Technology – Director
No.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Because they had decided not to do that at that point?

Deven McGraw – Center for Democracy & Technology – Director
That's right. I can go back and construct a timeline as to when things were actually teed up to CMS, the ONC, if it would make us feel more comfortable. But my sense is that those certainly were not, my recollection is that those were not in the original metrics that they used to craft the NPRM, but I'm happy to go back and check.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I thought they were.

Deven McGraw – Center for Democracy & Technology – Director
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I thought on the ....

Deven McGraw – Center for Democracy & Technology – Director
Both of those recommendations came from the privacy and security workgroup and not from us.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
....

Deven McGraw – Center for Democracy & Technology – Director
We had in the policy committee teed up, I'm sorry, as a meaningful use workgroup my recollection is that we had teed up the enforcement issue. If you're penalized, but we hadn't—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Deven McGraw – Center for Democracy & Technology – Director
—quite refined it to the level of being very specific in the way that I recall doing with the privacy and security workgroup. But I'm happy to go back and try to reconstruct that timeline. Then I guess the other question is, if we think it's an important point to make, why would we not make it even if the administration, the agencies are resistant?

Christine Bechtel – National Partnership for Women & Families – VP
What we had in the original metrics was compliance within the privacy and security rules, compliance with fair data sharing practices, and flipping page, quick work on the nationwide privacy and security framework.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
You're right, it wasn't there. So that gives us a license to submit it officially then, okay. Those were the originals that came in as was just stated a little bit later than the formal submission to NPRM process. How do people feel about putting those back in as a recommendation?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
If this is stating that hospitals doesn't get meaningful use incentives, if it's found guilty of a HIPAA infraction, I mean—

Deven McGraw – Center for Democracy & Technology – Director
A major HIPAA infraction, George, full neglect of the law, not just any old piddly thing.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
That's the problem is saying what size it is. In other words, if the penalty is $100,000, is that large enough that we should withhold the $9 million meaningful use incentive payment to that hospital. In other words, we have a single hammer, a single blow, and it's $9 million, yes or no. So we have to decide—

Deven McGraw – Center for Democracy & Technology – Director
Okay, so is it $9 million, I didn't realize a hospital could get $9 million in a year.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No, not a year, the first year would be—

Deven McGraw – Center for Democracy & Technology – Director
We said that the recommendation was phrased in terms of being ineligible in the year that you get dinged.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So then the maximum, I don't know how it works out for hospitals, I know the providers better, but is it like $5 million the first year or is it some other number?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's $2 million plus and enough for each discharge. So it's certainly right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
That's the $9 million.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, I think it can be up to $9 million—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Depending on how it gets spread out over years to be quite certain. Like they have to be able to get at least $3 million or $4 million in a single year. So we're deciding then, we have to pick only those infractions that are really worth withholding $3 million in addition to the HIPAA penalty.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well actually you bring up, one of the strategies is the way the word is, was that you had to be convicted. So a way for the same reason you suggested, if you're threatened with a $200,000 or $300,000 fine for your HIPAA violation, what you would do is settle out of court. You wouldn't get the conviction, so you can collect your $9 million.

Deven McGraw – Center for Democracy & Technology – Director
Basically, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No, but ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That was one of the outs, that's the way it would have worked.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

I don't know, if you're getting a $300,000 month penalty, then why are you getting a $3 million penalty also? If it's like an egregious thing, they should get a $3 million penalty from HIPAA. If the court is deciding it's worth $300,00 and that's the size of thing, then why are we increasing it by a factor of ten?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
First of all, it's not increasing—

Christine Bechtel – National Partnership for Women & Families – VP
Because we're not increasing the penalty, George, we're saying that if you have been found not to have, being engaged in prudent privacy and security practices, you ought not be eligible for federal incentive dollars and frankly other grants and contracts from the federal government if you can't manage your HIPAA processes well.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Right, because ....

Christine Bechtel – National Partnership for Women & Families – VP
It's not the penalties.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
If there's a total meltdown in the security and privacy of a hospital, I can understand that, but there's a certain rate at which hospitals suffer malpractice suits that they lose and a certain rate at which they have an employee who steals data or something else goes wrong. That's going to happen every year for every hospital at a certain rate ....

Deven McGraw – Center for Democracy & Technology – Director
This isn't the same as malpractice, George. In fact, nobody has actually ever been fined under HIPAA. I'd be happy to carve out the criminal instances that are due to one person, that are not enterprise liability that are on an individual. I mean this already went through the policy committee once. I guess, this is very frustrating to me, because if this workgroup is not the fruitful vehicle for this, then perhaps this ought to be punted to the privacy and security workgroup since we have one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Also George, there's no retraction of the incentive, it's a withhold until you pay up your money, until you serve the penalty that's been adjudicated.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's only with, so we just, it just felt unconscionable to hand you over this money for meaningful use when you're not handling the cases in a responsible manner.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Okay. Once you're found guilty and pay your fine, then you get your money?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, that's sort of the way the law works.

Deven McGraw – Center for Democracy & Technology – Director
That's actually not the way we phrased it.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's what I thought.

Deven McGraw – Center for Democracy & Technology – Director

That was the way we contemplated it before we got to the phrasing that ultimately was approved by the policy committee. Again, I'll go back and dig it out. But when we were contemplating in interim, like you are under investigation, so that's where we talked about a withhold, pending the investigation. Then once you were cleared or corrected your violation, you could get your money.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually Deven, I think we went through that process and then we ended up with the way I've described it. The reason was we didn't want people, because there can be spurious complaints, and you don't want to penalize them before they're found guilty. So the point was if they really are convicted and before they make restitution for that, then there's no payment of meaningful use monies, which depend on you complying with HIPAA.

Deven McGraw – Center for Democracy & Technology – Director
Alright, let me pick it up, Paul, because I don't think that's right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Deven McGraw – Center for Democracy & Technology – Director
Also we never triggered this for spurious violations. It is only for the most significant ones for which if ... have fined them, they are required to impose a penalty, and that is willful neglect.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So it sounds like we need to resurrect a timeline in the exact language and then we can bring it forth for this group again? Let me see if there is a sense of would people like to include what we have proposed in the past that was not in the rule as a draft for public comment in 2013?

Christine Bechtel – National Partnership for Women & Families – VP
I certainly would.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Can you remind us what that was?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're having a little difficulty of the exact wording.

Deven McGraw – Center for Democracy & Technology – Director
Yes, why don't I tee that up again. These recommendations, I'm torn here, because these recommendations, when we as a meaningful use workgroup first added privacy and security to the metrics, we did not have a separate privacy and security workgroup. Then we created one and the two recommendations of which I'm speaking that I would like to add came from the privacy and security workgroup. So I'm wondering now whether it's appropriate for this meaningful use workgroup to take on privacy and security issues when we have another workgroup dedicated to that purpose.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, but Deven, I'm thinking if we have the recommendations from that workgroup that they do not included in the rule. So I think at a minimum we should include the recommendations from that workgroup in the RFI for public comment. We need to clearly say, "Look, meaningful use has to protect privacy and security. It's foundational so if this doesn't work, tell us what will." But I think we've got to put that out for public comment and it does come from the workgroup. Now if we've got the time, we might go back and raise it for the workgroup and ask that if there's any refinements that need to be made, but that's up to you.

Deven McGraw – Center for Democracy & Technology – Director
Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think both for to expeditious, as well as to look at the chart for the workgroup it would be useful to have this workgroup endorse those recommendations.

Christine Bechtel – National Partnership for Women & Families – VP
That would be great.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think we need to dig up the original wording ....

Deven McGraw – Center for Democracy & Technology – Director
Yes, I'm going to do that right now but we can move on in the interim. I can—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. We may need to explain it and then we can get the sense of this workgroup. Okay, so that would conclude having a one through all these categories. One of the things we had on the parking lot was the whole, the confusion around access versus copy in the patient engagement section. Christine and Deven were going to talk, educate us further, and then see if we can fine tune the drafts we had last time.

Deven McGraw – Center for Democracy & Technology – Director
Okay.

Christine Bechtel – National Partnership for Women & Families – VP
I don't know about educating you or was somebody else trying to speak up?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Paul, just before we move on, just for the record, I think that, and Deven maybe you can validate this, I think that the max penalty in terms of the security violation is $1.5 million.

Deven McGraw – Center for Democracy & Technology – Director
That's correct.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
You can have multiple violations, so it could be pretty significant. And I think the argument is, is that deterrent enough? Yes, that's pretty significant if you have multiple violations, but I also agree with Deven, that that hasn't necessarily been exercised. I can argue the other side too, that maybe that's not the fault of meaningful use. But I know we'll come forward ....

Deven McGraw – Center for Democracy & Technology – Director
Yes, there's other reasons for that I suspect.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, and Paul, we don't have to do this now, but on one of our calls I want to go through that timeline and I think you should maybe walk through that again just as ... item.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Sure.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Okay, thanks.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Christine, did you want to speak to the copy access?

Christine Bechtel – National Partnership for Women & Families – VP

Yes, absolutely. So what we did was we went back as we talked about in the in-person workgroup meeting and sort of started at ground zero with what's the goal we're trying to achieve through access and copy? What is already in the rule, so that we could be mindful of creating a glide task that works for folks and gets us to that end goal. What we came to was that the goal is something like all patients are able to obtain their most current health data electronically, any useable format on a timely basis.

With that as the goal, we started to look at access and copy and we acknowledged a couple things. I should start by saying that we have an idea that I think is a good one, but probably needs some refinement. So we're here to hear what you all think. When we thought about copy, the most sort of significant attribute of copy was the ability to obtain the entire record, the historic medical record, knowing that the way that most provider offices implement, strictly in the office setting, is they don't go back and input 20/30 years of health information. So if you want a copy of your entire medical record historically that was what the copy function was for. But that access was really the goal that I just described. Obtaining your most current health information, being able to use that to either share with another provider or manage your own health care or either that of a family member.

When we thought about the notion of the glide task, what occurred to us was this, that if you look at the definition of the clinical summary, which is another way that patients could obtain access to their information. It's very comprehensive, number one, and it is a core item. So it's something that all providers in the EP setting will have experience with by 2013. So we thought that was probably the right building block. Let me tell you what's in, just as a reminder, what's in the definition of that clinical summary. It's patient name, provider name, date and location of visits, reasons for a visit, updated medication list, lab and other diagnostic tests, procedures and other instructions based on clinical discussions that took place during the office visit and vital signs.

When we looked at that and we realized that most providers would have experience, our suggestion is that we consider actually collapsing access copy and clinical summary into one requirement. That supports the glide task option and also gets us to some parsimony. What we're thinking is that in 2013 that the EPs would continue to do that, but that we could expand to the content to include what's already found in the CCR or CCD, which adds a couple things like insurance and family history and immunizations. And that there's a functionality addition as well in the EP setting, which is the blue button function.

The ability to download your data, which we recognize in 2013, would probably be mostly human readable, but useable in the electronic format. In other words, you could download it through a portal, either into a PHR interface or create a PDF out of it or some other thing that the market comes up with. That's what VA is already doing right now and CMS is going to do in the fall. So we know the technology definitely supports it. So that's EP 2013, going to something that is data in a more structured form in 2015.

In terms of hospitals, and then I'll stop talking, our suggestion is to take a very similar approach. That because the discharge instructions is really the patient applicant information domain at the hospitals, we felt like that needs to evolve. And if you look again at the clinical summary, a lot of it should be contained in the discharge summary anyway. So we'd like to propose that for the hospitals that they have the same requirements that EPs have for 2011, which is the clinical summary, but with the addition of the downloadable human readable functionality as well. But not to the expansion of the content as we're suggesting for EPs in 2013, that that would be on the list for 2015.

Let me stop there and first ask Deven if I missed anything?

Deven McGraw – Center for Democracy & Technology – Director
I don't think so other than did you cover the whole record copy issue?

Christine Bechtel – National Partnership for Women & Families – VP
Right. I started by alluding to it. So I think we have two options there, we can either eliminate copy completely at this point and just do this expanded summary approach or recognizing that it wouldn't be,

you have a right if you want a copy of your entire medical record. As of today, gliding does not have a particularly robust timeframe on it, which is 24 hours under 2011, and I think it's 30 days, right, Deven, under HIPAA?

Deven McGraw – Center for Democracy & Technology – Director
Yes, you can have up to 30 and then an additional 30 if you need it.

Christine Bechtel – National Partnership for Women & Families – VP
Right. So I think the option for the workgroup to consider is either to just go ahead and maintain that category, that requirement, and simply keep it the same. Clarify that it is a copy of your entire medical record within 24 hours, but that it doesn't change, it just gets clarified or folded in along with access into this expanded summary notion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
A couple of comments, one is, I don't think it applies to your entire record, it would apply to the record that exists electronically?

Deven McGraw – Center for Democracy & Technology – Director
Yes, that's correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
The other piece is, I picked up that there's an inconsistency with the way clinical summary is defined in the rule versus how it's defined in the certification specification. So CMS is aware of that and they'll probably issue some kind of clarification there. It seems like that may affect what you're doing as well?

Christine Bechtel – National Partnership for Women & Families – VP
I'm not sure what the discrepancy is, I'd like to hear that, but I do know Tony had told us that they will be issuing a technical correction piece. So I would imagine that would get covered in that, is that your understanding?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. The one that comes in the certification criteria is sort of the problems, meds, allergies, labs, not to do a more expanded kinds of things in the list that was in the rule.

Christine Bechtel – National Partnership for Women & Families – VP
Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That's correct.

Christine Bechtel – National Partnership for Women & Families – VP
What does that mean for, is the requirement likely to suffer or are the standards going to get more robust in your ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We don't know now.

Christine Bechtel – National Partnership for Women & Families – VP
I know.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
To be really honest here, if you can start to get meds, the data that's structured flowing, that's good news. I'll comment, I liked your glide path approach, and I think you should leverage all the work that's gone on to standardize this stuff and keep on that mark. I think it's going to help the industry a lot. I think building on in an organized way, especially with an eye toward the care coordination piece, I think will be helpful for the industry.

Deven McGraw – Center for Democracy & Technology – Director
So what does that suggest, Charlene, requiring the data to be structured in 2015?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Again, I think we need to look at what you need for care coordination linked to the data that's structured today. We should perhaps look at that content, we should prioritize it. Because I think the work in the industry has gone in to structure the medications, allergies, there's work toward problems, there's glide paths there, and again this will all take time, labs. Again, labs sometimes come back late, so there's a little bit of issue there we know that.

Deven McGraw – Center for Democracy & Technology – Director
Right.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And where there's gaps there, but then again there's a lot, like the vital signs. There's some work that's been pointed to, that's not standardized yet. So there's work going on, but it's not in the mainstream yet.

Christine Bechtel – National Partnership for Women & Families – VP
So the proposal that we've laid out is to make it human readable and portable in 2013, so it doesn't require all that work to get done before 2013. But what we are suggesting is that that work get prioritized and done before 2015 so that it is structured data for the full content of the CCD document, which covers all of what's already included in the NPRM under clinical summary. So it sounds like that's consistent with the approach you're suggesting, is that right?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Deven McGraw – Center for Democracy & Technology – Director
And CCR too.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Christine, the only other piece, and this is just, the piece that I think we've talked about that is important, if there's something we need for the care plan, we should just look at these pieces together and make sure there's something that doesn't pop out.

Christine Bechtel – National Partnership for Women & Families – VP
I think that makes a lot of sense is what did we end up, if somebody should remind me, doing on the care plan? I know we were talking about that under care coordination.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think we're pretty much ... right now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
There is something called a care transition performance set that has structured data in it. David Bates would be able to speak to this better, but that was—

Christine Bechtel – National Partnership for Women & Families – VP
There was also a summary of care record that's already a requirement in first phase one that is going to evolve. So I'm not sure how the elements of summary care record or a transition set crosswalk with these, but I think that's an important question.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs

Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well actually, summary of care record was not defined in the role, so that was left open. So one of the proposals from our hearing was that this care transition performance set be used for that, because it wasn't setting with transitions. David Bates are you still on?

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I am. I'm trying to remember, there was a specific group that had spelled out that transition set.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I just don't remember who it was.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I thought NQS was doing that. They had that project funded to look at that content.

Christine Bechtel – National Partnership for Women & Families – VP
I don't know, Charlene, I'm not even sure if it's funded anymore.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
Yes, I think it was somebody else, but at any rate there was a performance set that we could point to that seemed to be reasonably well established.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
In fact, I think it was a professional group—

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I think so too.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
—on this.

Christine Bechtel – National Partnership for Women & Families – VP
So perhaps, what we could do is if folks were comfortable with the glide path approach that Deven and I laid out today, go ahead and adopt that approach. So I would do some work offline to see what the elements of that transition set are and make sure that if anything we would need to consider adding them to the clinical summary, and then deciding based on any new content. At least under the approach that we're suggesting, some of the new content would go for EPs only in 2013, but not for hospitals until 2015 for that expanded content. So we'd have to go back and just make sure that approach still works.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Can I just point, there's three levels of structuring. There's stuff that you can only read, for example, an image of a written page, and we want to move away from that as quickly as possible. Then there's fully structured where everything is coded with a formal vocabulary, which is hard to do. Then there's this middle ground where it's semi-structured where you have fields that have say, here's where the history is or here's where the history of present illness is, here's where the diagnosis is, here's where the chief complaint is, but they're not necessarily coded. The CCD does include some fields like that, but that's not necessarily useable for care plan, but it's still structured enough that you can re-format it and send it off to the next provider or something.

Christine Bechtel – National Partnership for Women & Families – VP
Right, that's the approach we're suggesting for hospitals and EPs in 2013. Then by 2015 we get to the third approach that you outlined.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I'm not sure that we should, it depends on how much you want structured. Most experiments where they try to get doctors to structure everything they have to say, fail. So we have to be careful that we only pick whatever variables are critical to transform. You know what I mean? Otherwise you end up with a fully structured ....

Christine Bechtel – National Partnership for Women & Families – VP
Yes, but are you talking about 2015, George, or 2013, because we're not trying to get doctors to structure everything to 2013. We're just trying to get them to structure enough of the content that I defined that's already in the summary, so that it is readable by a person, ideally a PHR interface, another care provider, a portal, etc.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I guess what I'm saying, so I agree with the 2013, and then with 2015, I'm not sure, it depends on how far you want it structured. Like I'm not sure that even the 2020 goal have a completely structured thing unless it's somewhat automated, because experiments seem to show is that when you ask for too much structuring, you actually start getting inaccurate information, and doctors drop things off because they don't want to take the time to structure it, etc. When you move too much of the pretext, so we have to figure out what it is we're asking to be fully structured by even 2015.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I think that's a fair point.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Like knowing who the referring provider is, all that kind of stuff I think should be very structured. The allergies, the meds should be fully structured. Once you start getting into the symptoms and the past medical history, it gets more hazy.

Christine Bechtel – National Partnership for Women & Families – VP
I agree with that. I think too, because we want to start actually communicating patient preferences and some life circumstances, things that impact treatment recommendations, and that can't always be structured. Because we don't want to completely lose the narrative and the places where it's more the art of medicine than the science that gets pastured. So I think we're saying the same thing, which you structure as much of it as you can so that it becomes much more useful and useable by patients and providers, but leave open the right fields that don't need the structure because then you lose the art.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, I think that's important.

David Bates – Brigham and Women's Hospital – Chief, Div. Internal Medicine
I agree with George, I think a way around this is just to point to something like the CCD, which is going to evolve overtime and presumably in the sort of direction that we want to go to.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
And actually, and that was the proposal, so yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Can I bring up at this point, we do have just an economy between CCD and CCR, and I know there were people that were unhappy that there were two standards adopted, not that you can easily translate one to another. Do we want to have that persist through 2015 or should we focus in on one of them?

Deven McGraw – Center for Democracy & Technology – Director

I don't know why we would want to wade into that battle.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Deven McGraw – Center for Democracy & Technology – Director
I think it would be interesting to see if the market settles it out rather than the government choosing one over the other.

Christine Bechtel – National Partnership for Women & Families – VP
I think we ought to ask the standard committee who has expertise in that area for some thinking and guidance on it. But I agree with Deven, I thinking wading, I'm not at all prepared to wade into that debate. I just don't know the different between the two ....

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the comment was, because you explicitly said either, is instead of saying either, punt this to the standards committee and we may want to provide guidance saying, we think a single standard would move by 2015 will move this effort forward.

Deven McGraw – Center for Democracy & Technology – Director
I'm not in favor of pointing them in that direction. I mean generally, the ONC made a choice, not to make a choice. So as long as both are available, I think our recommendations should go to both. If we want to ask the standard committee whether it's time to specify versus another for 2015, I would do so, but would not be in favor of directing the choice, directing that it needs to be one.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, that's what I'm saying to ask them to look at that issue.

Christine Bechtel – National Partnership for Women & Families – VP
I'd rather ask them to look at the goal, Paul, here's what we're trying to achieve by 2013. Something that is—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Interoperable?

Christine Bechtel – National Partnership for Women & Families – VP
I hate to put a number on it, but yes, something that's interoperable, something that is possibly something like 90% structured, but leaves room for the art of medicine and communicating.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm not sure I was getting in that detail. I think we would suggest and would guide them towards achieving interoperability by 2015 as an example, recognizing that this is a semi-structured document. I guess what I was suggesting is not for the policy committee to go say CCR or CCD, leave that completely to the standards committee. Our goal is to achieve interoperability by 2015 so that all the systems can read this stuff and translate it both to human form, as well as make as much use of the structure that's available if possible. Is that fair?

Christine Bechtel – National Partnership for Women & Families – VP
That's good, yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So can we summarize what you're proposing for each of the groups then, EP and hospital, so we can try to put something in again this metrics? So we're up in engaged patients category, Caitlyn.

Christine Bechtel – National Partnership for Women & Families – VP

Yes, and I'll summarize, but I'll rely on you and Deven to watch the screen, because my Internet is not with me. The goal I think here is, because I know there's a column where we have with the goal that we're trying to achieve is. It's something like all patients obtain their most current health data.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so this is under which, again, you were going to combine, you were going to collapse copy and access, correct?

Christine Bechtel – National Partnership for Women & Families – VP
Actually, I think we have to decide what we want to do. We want to collapse access and clinical summaries at the office visit and have that apply to both EP and eligible hospitals; although, there will be a slight distinction between the two in the columns. So the collapsing is access and summary and then the question is whether we collapse copy in there as well or whether we clarify that copy is a copy of the entire medical record electronically, which could be scanned in, in PDF.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So just for our note keeping, Caitlyn, maybe we'll put this over in I think the column J, because I think we're more rough in this particular one. So one of the points is that we are attempting to combine row 41 and 43, which is electronic copy and clinical summaries.

Christine Bechtel – National Partnership for Women & Families – VP
No, it's access and summary.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, I messed it up. Okay, so that would be row 43 and 44, so just put a note to ourselves that we're trying to combine these two columns.

Christine Bechtel – National Partnership for Women & Families – VP
Paul, let me come back to a comment that you made, and Deven, I know you know, which is the ARRA provision regarding an electronic copy, it's only where the record is already kept electronically. So first of all is that correct?

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, that's correct.

Christine Bechtel – National Partnership for Women & Families – VP
So if that's the case, I'm trying to understand how that would be operationalized today. I mean it can't be 200 print screens, so I'm trying to understand if it's only really applicable for providers who have an EHR already. Then is there even going to be historic value or other value in getting everything in a record versus what we're outlining in summary, that's the question?

Deven McGraw – Center for Democracy & Technology – Director
Yes. And we talked about this, Christine,—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Why don't we list this?

Deven McGraw – Center for Democracy & Technology – Director
—whether there would be a need to reinforce the HIPAA ability to get an electronic copy of whatever parts of the record that you want, including the entire record as long as it's kept electronically. The proposed rule needs to settle issues of timing, cost, and has already talked about how the patient gets this is likely to be a negotiation between patient and provider in terms of what's going to work best. If

there's no download capability into a PHR for example, it may be that the transaction takes place using portable media.

On the one hand, while I like encouraging that, if we were arguing for parsimony, we could instead focus meaningful use on the timely obtaining of the clinical summary and let HIPAA pick up the whole record piece. Does that make sense?

Christine Bechtel – National Partnership for Women & Families – VP
Yes, it just means that what we would lose is the 24 hours.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Is that the three days?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
You're not going to lose the electronic piece, because HIPAA doesn't require that it be done electronically.

Deven McGraw – Center for Democracy & Technology – Director
It does if you have an electronic record.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Well no, it actually gives providers the option to do that if they have electronic record, so it might—

Deven McGraw – Center for Democracy & Technology – Director
What?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Deven McGraw – Center for Democracy & Technology – Director
Wait, restate that, Paul, because that didn't sound right to me.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Patients are allowed to request their information in electronic format if the provider can produce it that way, but the provider is not obligated to do that.

Deven McGraw – Center for Democracy & Technology – Director
No actually, that's what was changed in high tech.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That's what I'm saying—

Deven McGraw – Center for Democracy & Technology – Director
If you're using an EHR—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Wait, Deven, that's what I'm saying, high tech changed that, but I think somebody was recommending that we leave this to HIPAA, and HIPAA alone would not ...

Deven McGraw – Center for Democracy & Technology – Director
Yes, but those high tech things, okay, so I said that because ultimately what high tech did was modify HIPAA. It's all going to be wrapped up in a bow in the HIPAA regulations. There's not going to be two separate pieces of code that people have to pay attention to.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I see, okay.

Christine Bechtel – National Partnership for Women & Families – VP
Right. ARRA offended the HIPAA law.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So in other words, regardless of whether you qualify for meaningful use incentives, you're required to give information electronically if requested and you have it that way.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

Deven McGraw – Center for Democracy & Technology – Director
That's correct.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
My question for Christine and Deven is, was there anything in the patient engagement hearing that would tell you that somehow, give a reason why meaningful use ought to take on the full records that's missing from HIPAA? In other words, anything that was in the testimony that says you know something we have to do this ourselves?

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
And maybe not, because I like parsimony, but that's the first thing I'd be looking at.

Deven McGraw – Center for Democracy & Technology – Director
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, that's a really good question, George.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I guess that the 24 hour maybe the only one.

Deven McGraw – Center for Democracy & Technology – Director
Yes, and we've got the strong timing incentives in the meaningful use criteria, which you're right, we don't have in HIPAA at least not as of yet. We don't know what OCR is going to do in the proposed rule with respect to timing. It's very much an open question.

I think this adds also ability to access a copy of one zone record, to obtain a one zone record is a constant source of complaints from patients about HIPAA. They get told quite frequently that HIPAA doesn't even allow them to get a copy of their record, when in fact the opposite is true. It shows up in HHS' summary of top five HIPAA complaints. It's been in the top five for as long as they've been publishing that data. The one advantage to putting it in meaningful use is it kind of underlines it.

Christine Bechtel – National Partnership for Women & Families – VP
So I think what I'm inclined to do is for the purpose of ERI, to leave the distinction and leave in copy, and ask for comment on whether that's meaningful to patients or whether they're truly getting what they need out of the combined access summary bucket. Because I think it's the right question to ask, George, I don't think we specifically posed that detailed of a question in this context, which is why I think we're having trouble answering it.

But Deven's right, there's such I think a perceived power and malice among patients around getting access to their data, that's the whole, "Give me my darn data thing," that I worry that optically eliminating and combining everything, and then limiting the content through what we're proposing, which is an expanded summary, may not sit well. So I think I'd rather leave the distinction and leave copy, and then have the expanded summary, the sort of access summary component and ask for comment on it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Paul, I have a question, the summary does not include the progress notes?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It does not as specified in the rule anyway.

Christine Bechtel – National Partnership for Women & Families – VP
No.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I think that's the major difference in why you have to leave copy. Because I think that the piece that patients might very well want a copy of are the notes that are written about them, because that's where the content is often times in the clinical record. The rest are sort of things and things that are done and things that are measured and things that are taken and whatever, but the content of the note is the progress note.

Christine Bechtel – National Partnership for Women & Families – VP
I think that makes sense.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
And so I would—

Christine Bechtel – National Partnership for Women & Families – VP
Because nobody—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
I definitely would not want to water down anything that would make it harder for patients to get a copy of the progress notes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So let me just summarize where we are, which is I think nobody is recommending getting rid of copy, so it's still there. We're working on laying out the stage two and stage three criteria for the combined categories of clinical summary and electronic access.

Christine Bechtel – National Partnership for Women & Families – VP
So Paul, would it be helpful if I go row-by-row?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Sure.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Before, here's one other issue on combining access in summary. Remember the doctors have to be electronic, but patients don't. So whatever we end up with, there has to be an option where the patient gets a paper summary. In other words, okay, so as long as we put that in there, because the patient has to get timely access, but it may be a paper.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. So the way the rules written on clinical summaries, it does say per patient preference, but it is per patient preference and not for provider preference.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So when we combine that with access, make sure that that option still exists for patients who want it.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. So we would leave electronic copy of health information alone.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We haven't filled in the stage two by the way.

Christine Bechtel – National Partnership for Women & Families – VP
So it would be the same I think as stage one, right, which is still—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
....

Christine Bechtel – National Partnership for Women & Families – VP
Yes, so 50%.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay.

Christine Bechtel – National Partnership for Women & Families – VP
Although, this isn't upon request, right?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Christine Bechtel – National Partnership for Women & Families – VP
I don't know if there's a question if we want to get better timeliness than 50% or not, but I think it definitely stays at, at least 50%.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So Caitlyn, I can you just put a placeholder 50%, essentially you can copy stage one to stage two.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Does CMS cover the scope of the data copy?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
No, this is row 41, yes, just leave that 50%, okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I don't know if you can put a comment in there, but I vote for actually parsimony. I understand the need to signal this for all the reasons you've said, but the OCR rule, I don't think it's out yet. Is that right? So we don't even know what the rule is yet, and to overstep it, if it aligns with it and we can endorse it, that would actually be the best of all cases. But I would rather influence there rather having two separate things to try and figure out in this particular—

Christine Bechtel – National Partnership for Women & Families – VP
But it's already in the law, Charlene. So OCR is not going to do, this is not materially different from what's in ARRA. So I'd rather at this point leave it in for public comment.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Okay. And I'm just saying, it's my understanding that we don't have the final regulation yet, so when that comes out, we just need to, if we can be parsimonious.

Christine Bechtel – National Partnership for Women & Families – VP

Okay.

Deven McGraw – Center for Democracy & Technology – Director
I don't think that's a bad idea to make a note to ourselves to check the final rule.

Christine Bechtel – National Partnership for Women & Families – VP
A note to ourselves, yes.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That's all.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, okay. So then the next line is electronic copy of discharge instructions at hospital. So that actually, what we're proposing would be eliminated because it would be subsumed by—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Discharge instructions is different from discharge summary?

Christine Bechtel – National Partnership for Women & Families – VP
Pardon? Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
This was discharge instructions at the time of discharge, which you can do. You can't produce summaries at the time of discharge. So I think there was a specific thing this was trying to get to.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. So then those of you familiar with hospital processes, how do we get to your point where, is it possible for the hospital at discharge to provide a document that has their name, their provider's name, the date and location of the admission, the reason for the admission, and updated medication lists, last are the diagnostics? Okay.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, so the former were all part of the discharge instructions, the lab would not be because you may not have things back for example.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. So the other ones were lab and other diagnostic test orders or results.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Christine Bechtel – National Partnership for Women & Families – VP
I guess that would be for a hospital, the results, right, not orders?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Correct.

Christine Bechtel – National Partnership for Women & Families – VP
Okay, and then—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Things like the summary itself, the summary of your admission may not be. There's a brief thing in there, but the actual discharge summary often times is dictated and then it has its time to come back. So that's the difference, we're trying to get people, this is a transition of care .... You want to get people to follow up with their PCP, know what the new meds are, etc., that's why you want to have something in your hand electronically at discharge.

Christine Bechtel – National Partnership for Women & Families – VP
Right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Is the format for the discharge summary specified somewhere?

Christine Bechtel – National Partnership for Women & Families – VP
It would basically be the same as what's in the rule today for EPs. But what we're suggesting is the lab and other diagnostic orders would become lab and other diagnostic results. So the next category is procedures and other instructions based on clinical discussions that took place during the office visit. So that would become discharge instructions, which could be done, and then vital signs.

Neil Calman – Institute for Family Health – President & Cofounder
The one thing that's critical in my opinion in terms of hospital discharge stuff is the names and if possible specialties of the providers that saw the patient. That's the one most difficult thing for anybody to retrieve and a very important part of continuity of care for primary care is to know who the people saw and what specialty. Because that's right now information that's almost impossible to obtain otherwise.

Christine Bechtel – National Partnership for Women & Families – VP
Okay, so provider name is already on here, so now it would be plural, provider names. I agree with the idea of adding specialties. Is there any issue with that from a technical perspective?

Neil Calman – Institute for Family Health – President & Cofounder
I don't know.

Christine Bechtel – National Partnership for Women & Families – VP
I think we can ask for public comment.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Here's where we're really challenged. When we looked at some of these requirements as a ... we try and meet the ability to be able to give a patient a document at discharge. We're leveraging what's in health information exchange creating the CCD. So a lot of pieces that you're talking about transcend across multiple of these categories. The more these can be aligned, the more efficient, I mean we'll have to go back and be efficient anyway, but the more efficient even the provider can be.

So for instance, we talked about under care planning the need to be able to keep that list of care team providers. So I would think how does that fit into, that would be valuable on this clinical summary, but until that's there, it's hard to put it on the clinical summary, plus we have to know who they are. So those are the kinds of challenges that—

Christine Bechtel – National Partnership for Women & Families – VP
So can we come back though to the care plan thing, like can we just get through the hospital and the EP stuff on the patient gazing bucket. Because I agree with you and you're right, we should come back, but it seems to me that what we're asking for from the hospitals in terms of I guess what we're calling now a discharge summary, as opposed to just instructions does include provider names and specialties, but they would only be the ones in this hospital, who treated them. We're not asking the hospital to figure out who's on the rest of the care team necessarily yet.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. So Christine, I wonder, I love parsimonies, but I wonder if the uses and the content is so different that you would try to leave 42 as is, because it's just a different—

Christine Bechtel – National Partnership for Women & Families – VP

But I don't think it's different, Paul. There's only one difference according to what you've told me, which is that lab and other diagnostic test results may not be available. But every other field that the EPs are already required to do in 2011 is doable it sounds like in the hospital setting at the time of discharge.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Because discharge summary is a term of art, and what you've described is not everything that's on a discharge summary. I'm just suggesting there was a specific reason for making these instructions and there is some fields for the instructions available immediately, but not to try to combine discharge summary with clinical summary, which is sort of a new thing. Clinical summary is something that we created the phrase, discharge summary are a term of art.

Christine Bechtel – National Partnership for Women & Families – VP
Okay. I'm just trying to get the language around what we're trying to do, because I think we're all saying the same thing. But I guess we call it discharge instructions, but we go ahead and define what that is to be consistent with what EPs are already doing. Is that closer?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's closer.

Christine Bechtel – National Partnership for Women & Families – VP
Okay, help me out.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
There's three stages—

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We have like, in the standards world we've got this continuity of care document. For each one of these use cases, for example discharge, at transition of care, a discharge for doing a transition of care for a referral doing a transition of care when you're admitted. Each one of those use cases looks at the set of data necessary and then standardizes around that set. There's a lot of work in that space. So I think it's worth talking through these use cases, a lot of that it has been thought through and worked through. And that's kind of like, you want to ...

Christine Bechtel – National Partnership for Women & Families – VP
So can you send that, Charlene, can you send those to us? Because what we could do is, I think it's going to be easier for people to see something rather than hear it and react to it. We already have, what I've explained we've got written down. So if you send me those I will redraft this to include the definition for everybody to comment on.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Okay. To comment on, I think that would be great.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So there are three things, there's discharge summary, which is a legal document used for billing, and may not even be that, we use it only because they don't have the right thing. Discharge instructions is specific things told to the patient on the way out the door, telling them what to do next. Then there's a clinical summary of the hospitalization, which we named which would be analogous to what a clinical summary on the outpatient side, which we actually stuck into our regulation. On the hospital side, we didn't create such a thing, because this is a confusing issue that there's something called a discharge summary, which may be useless to us.

So what I would argue is that what you're looking for is a summary of the hospitalization to be available electronically, immediately; although, except for the fact that the labs aren't coming back and that we don't call it the discharge summary because that means something else.

Christine Bechtel – National Partnership for Women & Families – VP

Perfect, I like it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Then it's not the discharge instruction, that's a part of the summary of the patient's care. So because we're getting confused is because we named this thing for the ... of profession, but we never named it for the hospital. So that's what I think we should end up with.

Christine Bechtel – National Partnership for Women & Families – VP
Perfect.

Neil Calman – Institute for Family Health – President & Cofounder
So we need a little chart with those three things across the top and the content areas on the side, and figuring out which pieces need to be in which of those documents.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
And then what's the current state.

Neil Calman – Institute for Family Health – President & Cofounder
Exactly.

Christine Bechtel – National Partnership for Women & Families – VP
Yes. So that's a great idea.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So the one thing, George, is once you list it, the discharge, the summary of hospitalization is generally not available at the time the patient is walking out, so that—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But the summary that's available as of that date, which maybe missing the lab tests, but you can find out what everyone else knows as of that date. If you have access, you should be able to see what, because that summary is going to be generated automatically, that's not dictated by doctors, that's whatever we have currently that's in the list that's available. We can push that button the instant they're discharged, which should include their charge instructions plus a bunch of other stuff. The fact that the discharge summary is a legal document that just gets dictated later is a different issue.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I agree with George.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
The labs will show up three days later, so the patient comes back and says, "I want access again," then the labs maybe there.

Christine Bechtel – National Partnership for Women & Families – VP
Perfect.

Deven McGraw – Center for Democracy & Technology – Director
Sounds good.

Christine Bechtel – National Partnership for Women & Families – VP
That's exactly what we're trying to achieve here. We're just blame us for not being doctors and not knowing the legal terminology, but that's exactly right, George.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So I think a clear table with these things apparently named in a non-conflicting way, but also specify what you mean by each of these terms would be very helpful.

Christine Bechtel – National Partnership for Women & Families – VP
Okay, we will do that. Do you want us to then go through and take a shot at populating a version of the metrics that was sent out to us today along with that?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
For both areas, yes.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, and then if folks agree with it, we're good to go, and if they don't, we'll have more discussion.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. Let me ask one thing, I don't remember that we put the top, so I'm looking at row 42, which is discharge instructions, I don't remember that we put the top five primary languages in stage two.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I don't care.

Christine Bechtel – National Partnership for Women & Families – VP
Well, I think given what we are talking about with the hospital summary, I think it would be a stretch to have top five primary languages in stage two for the hospital summary, but we certainly should do that for stage three. Whether or not the discharge instructions contained within the summary of the hospitalization are in top five primary languages. I'm just not sure, I love it, but I'm not sure about the state of our readiness to do that. Neil, I don't know if you have thoughts?

Neil Calman – Institute for Family Health – President & Cofounder
Well ASAP, that's all I can say. I don't know what their state of readiness is either, but we need to do this as quickly as possible.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
Could we all just make a note for staff to propose it for 2015, but ask explicitly, can this be done sooner and if so for what five or three or what languages?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I like that.

Christine Bechtel – National Partnership for Women & Families – VP
Do we have common discharge instructions for it?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think that would be fair. So I think it would not be ready for stage two, but to understand better, even some distribution and develop all of this kind of translation would be useful for us to ....

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, and just to make a slightly nuance point, I think you may be right about not being ready for stage two, but I think before we decide that we ought to ask the question. Because if people come back and say, "No, no, the top three discharge conditions are "X" and we absolutely have to standardize discharge instructions in these four languages," then we shouldn't take that off the table.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I just wanted to ask Charlene, since you had mentioned there's been some work in this area, have people been working on translating CCDs to various languages.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think they've been working, there are global standards for CCDs, that's one thing. However, I have had to follow that up to see to what extent that's actually happened. But I can get that information as one of these.

Christine Bechtel – National Partnership for Women & Families – VP
I'll try and do your chart. If you can agree on your top column headings, I can do the side headings. And then I will also follow up on the use of languages.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So Christine, the discharge instructions are often handwritten, I put that in quotes to know those are just generated. So it would be pretty tough to get those immediately translated accurately to five primary languages. Those are things that seem to me, we're not ready for that. Otherwise, I would think we'd all be using it, but we're just not ready there.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Christine, if you want help on the table, you can just e-mail me. I won't be able to answer until tomorrow, okay?

Christine Bechtel – National Partnership for Women & Families – VP
Yes, that's great, because I go out Thursday/Friday. So I will work on it today and send it to you and Charlene and Deven and Neil.

Jim Figge – NY State DoH – Medical Director
I just wanted to raise a point, which might have been discussed earlier, with respect to releasing the hospital summary of events that happened during the hospitalization, as well as other records to patients that contain lab data. Have we figured out how we're going to handle the variety of state laws that regulate CLEA, because the Federal CLEA Act allows states to interpret who can actually provide the lab data to the patient. And a number of states, the state laws expressly say only the person who requested the test can provide the result to the patient. So that's—

Christine Bechtel – National Partnership for Women & Families – VP
Well then in this case, Jim, I think we're talking about the hospital ....

Jim Figge – NY State DoH – Medical Director
But that the state law still applies. But the laws in various states are all over the map in terms of what the requirements are. So I'm wondering how we're going to deal with the multitude of various state requirements on how laboratory data can actually be released to patients.

Christine Bechtel – National Partnership for Women & Families – VP
I just want to say two things, one, we have recognized that at least at the time of discharge it's likely that those results would not be available. But I think my question is, well, two things, one is CMS did release guidance on CLEA last year clarifying at least from the Medicare perspective, it's okay for consumers to get direct access from labs straight to consumers without the provider in the loop.

The cases that we're talking about here, we're talking about the providers being in the loop. So I assume and maybe it's not a correct assumption that if the hospital is the one ordering the test, that the hospital is the one that needs the data.

Jim Figge – NY State DoH – Medical Director

Well hospitals don't order tests, individual clinicians do. The strict interpretation of that law is that each clinician has to release the tests that they ordered. That's how it's interpreted for example in New York. Some states are very strict on that interpretation.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Really?

Jim Figge – NY State DoH – Medical Director
Yes.

Christine Bechtel – National Partnership for Women & Families – VP
I just don't know from a process perspective—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
....

Christine Bechtel – National Partnership for Women & Families – VP
I mean, it isn't about the clinician who's giving the instructions anyway, in a way it's not. We're not exactly defining lab and test orders, it's part of the hospital summary for this case. We're not doing that because we're assuming they're not available, so I'm not sure—

Jim Figge – NY State DoH – Medical Director
But lots of labs will be available.

Deven McGraw – Center for Democracy & Technology – Director
I think what we're aiming for is what's put in the provider record, the patient ought to have access to that too. We're not even talking about direct access from labs, but I think we have to be mindful in our percentages that the patients can get labs. I was trying to think if we needed to make some sort of accommodation for the fact that providers might not actually get a lab and that might have some impact on numerators.

But all of these, we had this CLEA discussion in round one is my recollection, which is why we didn't talk about going directly to patients. There's a delay and patients, what we're talking about is the patient's ability to obtain information that's been put in the provider record. So if it's in the provider record, then it's been delivered by the lab consistent with law.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
This may recover when we do our public comment period.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Deven McGraw – Center for Democracy & Technology – Director
But we will get comments on that if we're not entirely clear what we mean, which is that we're mindful of the fact that states have particular laws on who's allowed to receive a lab result from a laboratory. But in terms of the patient access piece of this, we're talking about patients being able to access what a provider has in his or her record.

Jim Figge – NY State DoH – Medical Director
But some states have laws that expressly control release of the data, who can release it. And in some states it's only the person who requested the test, that's the only person that's authorized to release it to the patient.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair

Being a New York State person, if my EHR gets the lab result back, that's because I've ordered it. It's my electronic health record. Are you saying that the patient, I can't just allow that data to be passed directly through to the patient instead of verbally—?

Jim Figge – NY State DoH – Medical Director
You can release it if you think—

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
No, I don't want to release it manually, I want it to be released automatically at the time I get it.

Jim Figge – NY State DoH – Medical Director
So that's a conscious choice that you make with your data. But somebody else who practices in your office may want to actually explain that data to the patient before they can get it. That's why some of these laws exist, because the feeling was that patients would not understand the lab data. The laws are there expressly to allow the person who ordered the lab data to explain it to the patient. That's why the laws exist.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But one more piece. So if I authorize my nurse to be able to do that, to read it from the electronic health record and explain it to a patient.

Jim Figge – NY State DoH – Medical Director
Well, you're still permitting it.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So basically the provider, all you're saying that we can't as a country create a rule that basically forces providers to instantly release their lab data or even after four days, if they haven't called the patient with it for the patient to have access to it. Is that what you're saying, Jim?

Jim Figge – NY State DoH – Medical Director
Well that would be true in the states that have those restrictive laws, right.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
So are we taking that into account in our—

Christine Bechtel – National Partnership for Women & Families – VP
I think that's also what Deven is posing, the question, which is if it gets into the record, does that imply that the provider has chosen to make it part of the record. They know that as a hospital that they are providing a copy of certain elements of that record to patients.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
But Jim's saying, no.

Jim Figge – NY State DoH – Medical Director
In New York.

Christine Bechtel – National Partnership for Women & Families – VP
Right. So I think that, I mean I'll just be on record saying I think those laws are ridiculous, but that being said I guess that they—

Jim Figge – NY State DoH – Medical Director
But there's a rationale for those laws.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I got that, but I just don't agree with it ....

Jim Figge – NY State DoH – Medical Director
The rationale is that patients won't understand the results unless somebody sits down and takes the time to explain them, that's why the law is there.

Christine Bechtel – National Partnership for Women & Families – VP
I know, it's the rationale that I disagree with, but it's irrelevant because it's in the law. So I understand the rationale, I completely find it revolting, but nonetheless I think this is find to ask for comments in the RFI.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
And I'm not sure that what we proposed here violates that, so I mean I think that ....

Deven McGraw – Center for Democracy & Technology – Director
I don't think it does either, so I don't know why we're having this conversation.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Let's move on, because it's an important point. I don't think we violated it by what we've said here. So Caitlyn on row 42, column J, could we make a note to ourselves, what we said was for ONC staff to investigate the feasibility and readiness of making discharge instructions available in primary languages.

We can figure out how many of those are as a result of that necessary. Do you see what I'm saying, 42J? Yes. So ONC staff to investigate feasibility and readiness to offer like discharge instructions in top x-primary languages. In 2015 to investigate feasibility to offer discharge instructions in top x-primary languages. What I meant by x is that we don't know how many yet, so that's the character x, yes. Then semicolon, 2015 and possible 2013. So in stage two, so column G, you could probably take the top five primary languages out for the moment.

Okay, so then I think Christine, Deven, George, and Neil were going to work on flushing out the rest of this.

Christine Bechtel – National Partnership for Women & Families – VP
And Charlene.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I'll start percolating something and we'll go from there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay, great. Let's see, are we finished then with this, with the section?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's hard to tell from the view that we have on the screen what else is under there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Can you scroll down a little bit, please?

Christine Bechtel – National Partnership for Women & Families – VP
I think we are because it only leaves education resources, which we already discussed and are maintaining.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right.

Deven McGraw – Center for Democracy & Technology – Director
Remind me, did we have the conversation about inflows of data from patients?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, we did. So we covered it under, I'm trying to find it here.

Christine Bechtel – National Partnership for Women & Families – VP
Well one, Deven's right, and I think there are two things that come to mind for me. One is we did ask the quality measures workgroup to look at patient input data, but that is in the context of a quality measure, which is probably not something like uploading blood sugar scores for somebody with diabetes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm seeing it here now, Christine.

Christine Bechtel – National Partnership for Women & Families – VP
Oh, good.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We said for 2015, offer capability to upload and incorporate patient generated data into EHRs and clinician workflows for 2015. For 2013, provide a mechanism for patient and their data, and then we were going to supply a list of data that we're explaining.

Christine Bechtel – National Partnership for Women & Families – VP
The other thing that I wanted to see if folks have a feeling about, what I think would be great for 2015 is rather than the action resting on the patient to have to go in and get access to their summary, whether it's a hospital or an EP, would be to have a subscribed function that at least notified them that new data is available in their record. So I wanted to see if folks would be amenable to having a placeholder for that for 2015 for the industry to comment on?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It is a common in the access area, it's a common functionality to provide notice when something's updated rather than relying on you to have to query, login everyday to figure out whether anything's changed. It's fine to mention that, it's a common thing to do just because it would unworkable otherwise really.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, so if we could just put, if Caitlyn could put something in 2015 to jog our memory that we need to ask for comment on that that would be great or signal our intent there.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So Caitlyn that is under the access one, which is 44, right. You can put have timely access, open parentheses. Well actually we haven't, okay so, one of the things we didn't do was put in percent, the threshold for stage two. So for clinical summary, we have 50% going to 90%, and so maybe 70% is what goes in row 43. Similarly, we have in the timely access we had 10% going to 90%, and so maybe I don't know something like 50% goes as a placeholder for stage two.

Christine Bechtel – National Partnership for Women & Families – VP
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So at the beginning of where you are, Caitlyn, no, at the beginning that would be 50% having timely access.

Christine Bechtel – National Partnership for Women & Families – VP
Actually wait, Paul, let me come back to that for a second, because the threshold baseline should actually be that associated with the clinical summary, not with the access. Because the threshold of 10% was based on the definition of patients actually accessing their record electronically, which since on the clinical summary, a, that's forming ... anyway, and b, that could be on paper per their preference.

So I think that that threshold for access actually doesn't apply anymore, because we're going to go to expanded summary. So in the table and the metrics that I send, I can propose some things.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. So you'll have to look at that carefully, because it changes to how the compliance is calculated. You may get tied up in a knot as you try to consolidate all of this stuff, because as you pointed out the denominators is different, etc. So just make sure you look at that.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, and we did, which was to really use the clinical summary particularly for EPs as the baseline. I think where we'll struggle is the hospitals, because that will just be different. So we'll look carefully at that.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So Caitlyn, this is have timely access and I think it's the open parentheses, and notification, close parentheses. Notification about, so close parentheses, sorry, and notification about, close parentheses, to their health information.

Christine Bechtel – National Partnership for Women & Families – VP
We're going to try to get rid of the notion of access, because the word has been what's confusing people. So I wouldn't waste too much time on it. We'll probably go with something more like expanded clinical summary, delivery or whatever.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So same caveat in cell number H45, we have five top primary languages if we copy down the ONC staff to investigate. So copy J42 down to J45. No, no, no, J to J. Can you undo that, yes, thank you. Okay, so there will be more to come on this one.

I think a couple other clean up items under the care coordination, we did not finish the stage two cell for this HIE kinds of things. I think what we, let me just check what we arrived at, which is, okay, so go down to care coordination, the case above that.

Christine Bechtel – National Partnership for Women & Families – VP
One of the things, Paul, that we were asking in care coordination was the status of NHIN Direct and whether ONC could advice on whether it would be functional and operational by stage two, because that makes a big difference in what we could ask for.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. Can you scroll over to the right, Caitlyn? We need to see the blue area. Okay, so can you put in the, let me see here, why don't we go ahead and put in stage two sets, G53, and ....

Christine Bechtel – National Partnership for Women & Families – VP
I feel like I want to yell bingo.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. You could put mandatory subject to the status of HIE.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
... or which one, 53?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
We're putting it, I think in 52, 53, and 54, because all these are, oh, actually, the 53, so 53 I think copied down to 54. Okay. Then I think actually we are fairly complete here. Okay, so the only open items I think we have is a follow up with some detail definition in the patient engagement area. My guess is we're going to need another call for that. Certainly, it would be under an hour, but unless we think, I'm suspecting we can't do this on e-mail.

Christine Bechtel – National Partnership for Women & Families – VP
I think that's probably right, Paul.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Don't we have a call on November 9th or is that—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I was trying to get it before the committee meeting, which is on the 20th.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Okay.

Judy Sparrow – Office of the National Coordinator – Executive Director
I could try to set up a call. I'll work with you, Paul and George, to get space on your calendar.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. That would be great. Any other loose ends from the group?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes, Paul, this is a commentary. Last time we actually deleted things like close loop and some of the process, actually there were some more nursing things and close loop really meant bar coding. The argument was, well, we're going to use measurement instead. It seems to me that we have kind of a dichotomy here where we have some things being dependent on what comes out of the quality workgroup and other things that are not. You could argue, I could use measurement to detect errors and the use of CPOE rather than putting CPOE on, because again, it's intent is to reduce errors in many cases, as well as other things or improve quality.

So I just kind of challenge the group to, I don't see how we can take things off and say we're going to use measures when we don't take other things off. That just doesn't make sense to me until we see what the measures—

Christine Bechtel – National Partnership for Women & Families – VP
Charlene, are you suggesting we consider removing CPOE, is that what you're saying?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I was suggesting we put back on a few things until we see the measures, and then we look at the whole thing and say where we might be able to decrease some content. So I was actually going the other way.

Christine Bechtel – National Partnership for Women & Families – VP
Yes, I think Charlene's raising an important point, which is the need once we do have something back from the quality measures to go back and be parsimonious. So is our November 9th call too late for that or can we use it for that purpose?

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
November 9th would be good. What we'll be doing then is we'll have gotten feedback from the full committee. We'll try to digest that, go back through the whole thing again, and if there's been broad guidance like, you know what, let's get fewer measures, the whole parsimony guidance, then we might have more work in front of us. But depending on the feedback, we'll be working on the update before we go into an RFI process. To me, that's November 9th, I hope is more than one hour. It's two hours, okay. Yes?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Someone suggested to me the possibility of an alternative, that is either you meet the quality objectives early if you're capable of doing that or you have to meet a bunch of structural measures to prove that you're on the road. That that actually would be a concept of meaningful use. Either you meet the outcomes or you have to prove you're doing a lot of structural stuff to try to do it. So it should be—

Christine Bechtel – National Partnership for Women & Families – VP

George, it's an interesting concept, then are they suggesting that providers be accountable for achieving a certain threshold on a quality measure, because I think that's the only way that that works? Because right now, you don't have to achieve a threshold, you just have to report what your percent is.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, that is correct.

Neil Calman – Institute for Family Health – President & Cofounder
But also that enables us, a provider to achieve that outcome, possibly not using the technology that we're trying to meaningful use. Some of those outcomes can be achieved without the technology potentially.

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
That's right, and so is that a good thing or a bad thing for the nation, I'm not sure. We don't want them not using an EHR at all, but since we can't guess what's actually going to succeed, it maybe that innovative institutions come up with other ways to achieve important objectives, using an EHR, but not using it the way we expected. So it would just leave, I'm not saying it's necessarily a good idea, I'm just suggesting it as one tool we have in our toolbox.

Christine Bechtel – National Partnership for Women & Families – VP
Is it something we should request folks to comment on once we have the outcome measures back from the quality workgroup?

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Yes, we'll have to see what they're doing.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I think it's an interesting concept for sure, but I think the major implications meaning all of a sudden ONC will have to set thresholds. A lot of where we got to is due to the heterogeneity in the field out there, especially when it's such low ... right now. I think it'll be very, very tough to set a threshold for everybody and be meaningful. One of the directions that the quality field is going is actually even looking at trends, because ....

George Hripcsak – Dept. of Biomedical Informatics Columbia University – Chair
Agreed.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. So in other words, it adds yet another complexity, but prescription in the mix. I don't know that that's consistent with where we've been, but it's an interesting idea.

The other thing is clearly what we're trying to do is when we do that structural measure, we're trying to make sure that that's based as much as possible on evidence that those structures, those functions really have been proven to do good. That we are building somewhat of a floor that says these are things that every system should have in it to give the provider and the country as much flexibility in achieving the outcomes goal as we can get.

Anything else?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
So Paul, I'm just putting an objection on the table to eliminating some of the things we eliminated last time.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
To un-eliminate?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Where would you want to do that?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
That was row 32.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Caitlyn, can you scroll up to row 32? Okay.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
It's really not close lip medication management, because that's inclusive of CPOE by definition. It's usually bar coding. I think we had that in a previous version. I don't know if it got morphed a bit.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So bar coding, would you consider that part of the, well, I guess it is.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
We had it defined in a previous one like medication administration check, I don't know. I don't recall. There was a previous one, but close was implied. You placed the order CPOE, it flows to pharmacy, it flows back to administration checking function, that whole process.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So how do people feel about this? David Bates, you were on the last meeting, you might want to weigh in on this. Anybody else want to weigh in on this? I think what Charlene's asking is to be prescriptive on, this is sort of a barcode administration EMAR function, correct?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Right, right. I mean, and it's pretty pervasive in the industry and it's strongly demonstrating phase D, and it's the last line of defense if you will, so it's pretty important. I think it's really important. And I think maybe this just assumes that people are doing it anyway and they can just check the box, but it's a very important function.

Christine Bechtel – National Partnership for Women & Families – VP
What would be the objection to it? I'm not hearing any.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I know, right. I'm not hearing any. I'm totally in favor of moving to outcome space, but I don't see how you can—

Deven McGraw – Center for Democracy & Technology – Director
Yes, Charlene, I remember this. This came up in the comments after our face-to-face meeting where we had in our meeting sort of maybe on an interim basis concluded that a measure would take care of this. Then I remember getting comments on this that this was a very important patient safety issue and we needed something stronger in the measures versus just looking at outcomes, because it's really making sure that a step-by-step process actually occurs, right?

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
Yes.

Deven McGraw – Center for Democracy & Technology – Director
Okay. I'm not oppose to, I think I was one of the ones who pushed for an outcome measure without a full understanding of what this was. So I certainly wouldn't be opposed to putting it back in as a specific measure.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO

Anybody else? I think there was probably, one of the other points that was raise was the parsimony. So it's getting the outcomes and parsimony, because this was prescriptive in terms of your adding a new ....

Christine Bechtel – National Partnership for Women & Families – VP
So I think what Charlene is suggesting is that we would use some of the November whatever call to go back through once we have the quality measures. So this could be something that comes out. But I think it's safer to leave it in for now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Okay. So Caitlyn, on C32, could you change that label, instead of close lip medications, to actually just call it and say use barcode administration and EMAR.

Charlene Underwood – Siemens Medical – Director, Gov. & Industry Affairs
I think that's fine for now and there's probably some other—

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Right. And then put the EH at the end too. So use barcode administration and EMAR, and then open parentheses, EH, close parentheses. Then over into comment field, for that we can put, what is that 32? Maybe put a question mark at the end of that. Okay, anything else?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Yes, Paul, I just wanted to bring back something that came up during the population health testimony. There's been a concern since stage one, there has been a drive to allow genetic testing and hearing to be exchanged between those who do those tests and the EHRs where those kids are seen.

That didn't get into stage one, and there was a request to once again bring that back in stage two. Most of the genetic testing is done at state lab. So that state labs would need to exchange the data with the EHRs. This might be something we could call a quality measure for pediatricians or family doctors. But I just wanted to bring that back since I think we'll probably get comments about that again when we go out to the RFI.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Actually, can you restate the requirement then?

Art Davidson – Public Health Informatics at Denver Public Health – Director
So it would be that the EHR, the eligible provider is able to receive and share newborn genetic and testing and hearing screening information through an HIE.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'm not saying it's bad, but how do we justify each element we add here?

Art Davidson – Public Health Informatics at Denver Public Health – Director
Most of the testing is done at the state labs.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I see. So it's almost for the provider to get it back electronically.

Art Davidson – Public Health Informatics at Denver Public Health – Director
Right.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Do you think that they're ready to do this?

Art Davidson – Public Health Informatics at Denver Public Health – Director
I don't know that all states are ready to do this. There probably are some that are ready to do this. Children in vulnerable groups were considered a special call out in the original legislation. I think HRQ is

now working on a pediatric record and some formatting. They have a contract out around that. I don't know that it's ready for primetime in stage two, but I think it maybe something we're headed toward maybe for stage three.

Neil Calman – Institute for Family Health – President & Cofounder
This would be kind of a direct query in response kind of a thing that you're talking about?

Art Davidson – Public Health Informatics at Denver Public Health – Director
I don't really know yet, Neil. It may be a push because it's known where the child is being seen. It maybe a query response as you're saying. I don't really have a good handle on this, but I wanted to bring this back, just as we had items that we kind of took off the list but they persist in this new metrics. I'd like for this to maybe appear there for us to consider as we move forward.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Would it be good to at least get some of these questions answered before putting it on? I mean we could put a placeholder to go investigate this. In this whole group, I'm just nervous, I mean we had the chance of stirring up things and not—

Art Davidson – Public Health Informatics at Denver Public Health – Director
Not having an answer. I agree with you.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Art Davidson – Public Health Informatics at Denver Public Health – Director
I'm just trying to make sure that we don't continue to look at public health as specifically these three data types that we have there. The public health community has been trying to insert others. This one is probably one that has surfaced more than many others.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
So we have goals that we want to do with public health. How much can we do with this particular lever, which is actually not a lever above over public health, but the fact that they wanted it to be? It's a lever with the providers. As much as this will benefit it, the area where the infrastructure is weak is at the public health system. So would it make more sense for HHS or the federal government to work on this problem rather than trying to make a lever onto the providers? It feels a little misplaced.

Art Davidson – Public Health Informatics at Denver Public Health – Director
It could be once again where applicable.

Christine Bechtel – National Partnership for Women & Families – VP
The challenge I'd have with that is I think there's a lot of, even direct EHR functionalities that weren't quite ready for primetime that we all agreed to leave off because of just the wide variation and provider readiness and the infrastructure. So this seems to fall into that category formula, but I could be wrong. But it just seems like there's a lot of variation in infrastructure needs that need to happen first.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
It's a lot less under the control of even the provider or the vendors of EHRs, that's where I'm getting more discomfort. So I think we want to keep this need in mind. I think there needs to be another venue almost where we look at the public health system and the IT infrastructure for it and see how we can better improve it.

Jim Figge – NY State DoH – Medical Director
There's a workgroup through HERSA that reports to the Secretary's Advisory Committee for newborn screening and they are actively working on this very issue. I think that there will be a strong recommendation coming from that advisory committee on trying to include this in a future phase of meaningful use. So it might be appropriate to loop to that committee and see where they're at.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes. So for example if they start investing in this area, then clearly that would be the time when we would work on, let's say 2015, when the infrastructure is getting put in place. If there's already a direction and then there is a receiver and a readiness, I think we would jump all over this and providers who would like it right now. It just feels like we're asking them to do more and more, and especially in this area where they have less control over it, it just feels like the wrong lever we would be pushing at this time. It would be great if the HERSA Committee recommended the investments in this kind of infrastructure and we saw that movement, then I think we'd be very responsive.

Art Davidson – Public Health Informatics at Denver Public Health – Director
That's reasonable. Thank you, Paul.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Anything else? Okay, now I'm sure understand the document to protect this work. Anything else, and then we are going to look for another hour time to discuss the updated patient engagement metrics? Well thank you, everyone, for making time, it's very difficult.

Judy Sparrow – Office of the National Coordinator – Executive Director
Paul, we need to do a public comment.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Oh, yes, I'm sorry. Public, can you open up the—

Judy Sparrow – Office of the National Coordinator – Executive Director
Yes, operator, can you see if anybody from the public wishes to make a comment at this time?

Moderator
Our first comment is from Shantal Orazala with AJ Solutions.

Shantal Orazala – AJ Solutions
Good afternoon and thank you all for having this meeting, and you're making good progress. I just wanted to note a couple of things. On the public health discussion, I think there is a lot of willingness in the hospital community to contribute to public health and do this reporting. But we really do need this committee and ONC and CDC to work together to take the steps that are needed to standardize the reporting and to standardize the actual data requested by each public health department.

It's not just 50 state health departments, there are also 3,000 counties in this country, each of which have public health departments that ask for reporting of these kinds of data. So there's a huge, huge, huge public need for standardizing both the content of what's requested in the format for submitting it. So please don't just ask the providers to do it, please also help the public health community get to a place where they're all asking for the same data in the same format.

On Dr. Figge's point about the release of the lab results, I think his point was that it is not actually the hospital that has the authority to release the results of a lab test, but it's actually the physician who ordered the test that controls disclosure. So that the hospital cannot actually release those lab data without the physician first authorizing that. So I think that's the key point about including lab results in any kind of hospitalization summary or discharge summary.

On the discussion about HIPAA, there is a very, very strong concern among the provider community that we not have duplicative and potentially contradictory regulations of the same thing, which is privacy of health information. So definitely find out first what it is that OCR is doing those in terms of specifying data to disclose and timelines and penalties. The penalties are much, much stiffer now than previously as indicated $1.5 million, and you can have that assessed multiple times for the same event. It's $1.5 million per type of violation. A pretty strong deterrent.

On the question of bar coding, RFID closed loop, med management, concern that you not freeze technological innovation by using the word barcode, because in fact many hospitals are using RFID and not barcode. Here is a very good place where I suggest you ask ONC staff to look very carefully across types of providers to understand whether or not this type of thing makes sense for critical access hospitals and small rural hospitals. I believe that that should be done for every single one of these recommendations that you make. These are facilities, critical access hospitals that have on average net revenues of about $600 million per year. That's for everything that they fund including their reserves and all capital resources. So think about the different types of facilities you're addressing as you look at this.

Finally just a little bit of a concern about the notion that you give patients an indication or some sort of subscribed function for updates to their record. I want to make sure we all think through what that could possibly mean in terms of privacy risks and does it need to be secured e-mail and all of those sorts of things. So just make sure that's thought through in the context of maintaining privacy and security of records. Thank you very much for the opportunity to comment.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you for some very informative comments.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes.

Moderator
Our next comment is from Tray Senito of Autism.

Tray Senito – Autism
Hello, I've actually submitted some Britain comments just trying to make some comments during your discussion about public health and newborn blood spot and newborn hearing screening. Basically, I would agree with the last speaker who said that there needs to be consistency in the transmission of data from EHRs to public health. That just makes good sense that the EHRs be asked to submit a simple single message with specific data that would work for the various programs.

I think particularly with some of the children's programs, that's clearly possible with final records, with hearing screening, with blood spot screening, with immunization records. I also would like to support the idea that blood spot and hearing screening become a part of meaningful use in the near term rather than in the longer term. So in other words, in 2013 rather than 2015.

I think that both HERSA and CDC are putting a lot of effort working with states to be able to access these data electronically, and states are moving in that direction and able to do it. While there are some differences for example, hearing screening is done at the hospital, not at the state lab, so they are different in the mechanisms of transmission. They both should be submitted to public health in a timely fashion so that public health can continue with its activities that it needs to proceed with in terms of assuring care for every child. Thank you.

Moderator
We do not have any more comments at this time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, we'll turn it back to Dr. Tang.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
Yes, thank you for your comments. They are very informative. Just as a quickie, the comment about the barcodes, Caitlyn, could we change the labeling to automated medication administration management, something like that, and that will get away from the prescribing a specific technology, which was an appropriate comment.

Then I think this whole public health, I think we need more due diligence on what's the state of the practice and the readiness and where we're headed. I think it was Jim who talked about HERSA, if we could understand more of what's going on would inform us.

Jim Figge – NY State DoH – Medical Director
Paul, I will ask that HERSA Committee to prepare a formal statement to us so that we can see what the state-of-the-art is right now.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
That would be great. Okay, well thank you very much to the workgroup and see you next call. We'll try to get something before the 20th so that we can finalize the patient engagement. Thanks to the public who's listening in.

Judy Sparrow – Office of the National Coordinator – Executive Director
Thank you, all.

Paul Tang – Palo Alto Medical Foundation – Internist, VP & CMIO
I'll see you next time.

Judy Sparrow – Office of the National Coordinator – Executive Director
Goodbye.

Public Comment Received During the Meeting

1. Can you make the 1 hour call public?

2. None of the hearing testing is done at the state lab only the bloodspot testing. There is an IHE Technical Profile for hearing now we are moving to be able to do this for blood spot and hearing. Please do not forget about this as it is the first encounter of the child with public health. PH is investing in this area now there is readiness now hrsa and cdc have invested in this infrastructure

3. Under the current discussion, there are many lab orders by potential multiple clinicians, therefore you would have to coordinate all of the clinicians which would be difficult.